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## New York State Department Of Health
### Delivery System Reform Incentive Payment Project
#### DSRIP Implementation Plan Project

Advocate Community Providers, Inc.  (PPS ID:25)

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New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc. (PPS ID:25)

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NYS Confidentiality – High
Quarterly Report - Implementation Plan for Advocate Community Providers, Inc.
Year and Quarter: DY1, Q1  Application Status: 🚀 Submitted

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### Status By Project

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<tr>
<td>2.a.i</td>
<td>Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management</td>
<td>Completed</td>
</tr>
<tr>
<td>2.a.iii</td>
<td>Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services</td>
<td>Completed</td>
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<tr>
<td>2.b.iii</td>
<td>ED care triage for at-risk populations</td>
<td>Completed</td>
</tr>
<tr>
<td>2.b.iv</td>
<td>Care transitions intervention model to reduce 30 day readmissions for chronic health conditions</td>
<td>Completed</td>
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<tr>
<td>3.a.i</td>
<td>Integration of primary care and behavioral health services</td>
<td>Completed</td>
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<tr>
<td>3.b.i</td>
<td>Evidence-based strategies for disease management in high risk/affected populations (adult only)</td>
<td>Completed</td>
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<tr>
<td>3.c.i</td>
<td>Evidence-based strategies for disease management in high risk/affected populations (adults only)</td>
<td>Completed</td>
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<tr>
<td>3.d.iii</td>
<td>Implementation of evidence-based medicine guidelines for asthma management</td>
<td>Completed</td>
</tr>
<tr>
<td>4.b.i</td>
<td>Promote tobacco use cessation, especially among low SES populations and those with poor mental health.</td>
<td>Completed</td>
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<tr>
<td>4.b.ii</td>
<td>Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)</td>
<td>Completed</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
Section 01 – Budget

☑ IPQR Module 1.1 - PPS Budget Report

Instructions :

This table contains five budget categories. Please add rows to this table as necessary in order to add your own additional categories and sub-categories. The budget categories used in this table should reflect the budget categories you used in your application. If budget entered varies from PPS application or previous implementation plan submission, please describe changes and justifications in box provided.

<table>
<thead>
<tr>
<th>Budget Items</th>
<th>DY1 ($)</th>
<th>DY2 ($)</th>
<th>DY3 ($)</th>
<th>DY4 ($)</th>
<th>DY5 ($)</th>
<th>Total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Revenue</td>
<td>53,823,271</td>
<td>57,357,917</td>
<td>92,754,950</td>
<td>82,134,154</td>
<td>53,823,271</td>
<td>339,893,563</td>
</tr>
<tr>
<td>Cost of Project Implementation &amp; Administration</td>
<td>16,146,980</td>
<td>17,207,375</td>
<td>27,826,484</td>
<td>24,640,246</td>
<td>16,146,981</td>
<td>101,968,066</td>
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<tr>
<td>Revenue Loss</td>
<td>6,458,793</td>
<td>6,882,950</td>
<td>11,130,594</td>
<td>9,856,098</td>
<td>6,458,793</td>
<td>40,787,228</td>
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<td>Internal PPS Provider Bonus Payments</td>
<td>20,452,843</td>
<td>21,796,008</td>
<td>35,246,881</td>
<td>31,210,979</td>
<td>20,452,843</td>
<td>129,159,554</td>
</tr>
<tr>
<td>Cost of non-covered services</td>
<td>2,691,164</td>
<td>2,867,896</td>
<td>4,637,748</td>
<td>4,106,708</td>
<td>2,691,164</td>
<td>16,994,680</td>
</tr>
<tr>
<td>Other</td>
<td>8,073,491</td>
<td>8,603,688</td>
<td>13,913,243</td>
<td>12,320,123</td>
<td>8,073,490</td>
<td>50,984,035</td>
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<td>Contingency Fund</td>
<td>5,382,327</td>
<td>5,735,792</td>
<td>9,275,495</td>
<td>8,213,415</td>
<td>5,382,327</td>
<td>33,989,356</td>
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<tr>
<td>Other</td>
<td>2,691,164</td>
<td>2,867,896</td>
<td>4,637,748</td>
<td>4,106,708</td>
<td>2,691,163</td>
<td>16,994,679</td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>53,823,271</td>
<td>57,357,917</td>
<td>92,754,950</td>
<td>82,134,154</td>
<td>53,823,271</td>
<td>339,893,563</td>
</tr>
<tr>
<td>Undistributed Revenue</td>
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Narrative Text :

Budget above is consistent with the percentages and distribution dollars as described in the original application due December 2014. Percentages contemplated were discussed by members of ACP prior to submission of the original application. The numbers assumes earning 100% of 'Net Project Valuation' amount listed in the PPS Award Letter.
Advocate Community Providers, Inc. (PPS ID: 25)

**IPQR Module 1.2 - PPS Flow of Funds**

Instructions:

In the table below, please detail your PPS's projected flow of DSRIP funds for the next five years, splitting out the flow of funds by provider type. The provider types match the categories used for the Speed & Scale portion of your Project Plan Application.

- This table requires your funds flow projections on an annual basis. Subsequent quarterly reports will require you to submit your actual distribution of funds to these provider categories on a quarterly basis.
- These quarterly submissions of actual funds distribution will ultimately be required at the provider level (as opposed to the provider type level required here).

<table>
<thead>
<tr>
<th>Funds Flow Items</th>
<th>DY1 ($)</th>
<th>DY2 ($)</th>
<th>DY3 ($)</th>
<th>DY4 ($)</th>
<th>DY5 ($)</th>
<th>Total ($)</th>
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<tbody>
<tr>
<td>Waiver Revenue</td>
<td>53,823,271</td>
<td>57,357,917</td>
<td>92,754,950</td>
<td>82,134,154</td>
<td>53,823,271</td>
<td>339,893,563</td>
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<tr>
<td>Primary Care Physicians</td>
<td>11,841,119</td>
<td>12,618,742</td>
<td>20,406,089</td>
<td>18,069,514</td>
<td>11,841,120</td>
<td>74,776,584</td>
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<tr>
<td>Non-PCP Practitioners</td>
<td>2,691,164</td>
<td>2,867,896</td>
<td>4,637,746</td>
<td>4,106,708</td>
<td>2,691,164</td>
<td>16,994,678</td>
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<td>Hospitals</td>
<td>7,363,001</td>
<td>7,846,539</td>
<td>12,688,838</td>
<td>11,235,918</td>
<td>7,363,001</td>
<td>46,497,297</td>
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<td>Clinics</td>
<td>285,030</td>
<td>303,749</td>
<td>491,200</td>
<td>434,955</td>
<td>285,030</td>
<td>1,799,964</td>
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<td>Health Home / Care Management</td>
<td>663,996</td>
<td>707,601</td>
<td>1,144,279</td>
<td>1,013,256</td>
<td>663,996</td>
<td>4,193,128</td>
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<td>Behavioral Health</td>
<td>932,736</td>
<td>993,990</td>
<td>1,607,407</td>
<td>1,423,353</td>
<td>932,736</td>
<td>5,890,222</td>
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<td>Substance Abuse</td>
<td>932,736</td>
<td>993,990</td>
<td>1,607,407</td>
<td>1,423,353</td>
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<td>5,890,222</td>
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<td>Skilled Nursing Facilities / Nursing Homes</td>
<td>526,731</td>
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<td>907,729</td>
<td>803,791</td>
<td>526,731</td>
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<td>Pharmacies</td>
<td>251,955</td>
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<td>Hospice</td>
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<td>Community Based Organizations</td>
<td>447,267</td>
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<td>770,789</td>
<td>682,528</td>
<td>447,267</td>
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<td>All Other</td>
<td>27,700,079</td>
<td>29,519,180</td>
<td>47,736,218</td>
<td>42,270,238</td>
<td>27,700,078</td>
<td>174,925,793</td>
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<tr>
<td>Total Funds Distributed</td>
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<td>92,754,950</td>
<td>82,134,154</td>
<td>53,823,271</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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**Narrative Text:**

Budget percentage allocations listed below is consistent with the funds flow model that was outlined in our original application due December 2014.

NYS Confidentiality – High
Advocate Community Providers, Inc. (PPS ID:25)

-22% to Primary Care Physicians
-5% to Specialists
-11% to remaining providers (including Hospitals)
  -Projection of involvement by project and level of effort of each project by each provider category determined that determine allocation
  -Percent rolled up to PPS as a whole (all 10 projects)
  -Overall percent applied to this category to determine allocation by provider type
  -12% Revenue Loss included under Hospital category
-62% under ‘All Other’ and includes: Cost of Project Implementation (30%), Costs of Services Not Covered (5%), Contingency Fund (10%), Other (5%).
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc. (PPS ID:25)

IPQR Module 1.3 - Prescribed Milestones

Instructions:

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
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<tbody>
<tr>
<td>Milestone #1</td>
<td>In Progress</td>
<td>Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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Prescribed Milestones Current File Uploads

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Prescribed Milestones Narrative Text

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<th>Narrative Text</th>
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</thead>
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<tr>
<td>Complete funds flow budget and distribution plan and communicate with network</td>
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</table>
Instructions:
Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
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**PPS Defined Milestones Current File Uploads**

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**PPS Defined Milestones Narrative Text**

<table>
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<th>Narrative Text</th>
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NYS Confidentiality – High
IPQR Module 1.5 - IA Monitoring

Instructions:
Section 02 – Governance

**IPQR Module 2.1 - Prescribed Milestones**

Instructions:

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.

Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

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<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
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<th>Quarter End Date</th>
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<td><strong>Milestone #1</strong></td>
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<tr>
<td>Finalize governance structure and sub-committee structure</td>
<td>In Progress</td>
<td>This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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<td>Task 1</td>
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<td>1 Complete ACP Board Structure</td>
<td>04/01/2015</td>
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<td>06/30/2015</td>
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<td>Task 2</td>
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<td>2 Complete ACP Committee Structure</td>
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<td>Task 3</td>
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<td>3 Select and confirm ACP Board of Directors</td>
<td>04/01/2015</td>
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<td>Task 4</td>
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<td>4 Appoint ACP Officers</td>
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<td>06/30/2015</td>
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<td>Task 5</td>
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<td>5 Approve Bylaws</td>
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<td>06/30/2015</td>
<td>06/30/2015</td>
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<td>Task 6</td>
<td>Completed</td>
<td>6 Establish Steering Committee</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
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<td>Task 7</td>
<td>In Progress</td>
<td>7 Select Committee Chairs/Co-Chairs</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 8</td>
<td>Completed</td>
<td>8 Finalize ACP subcommittees and membership</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
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<td>Task 9</td>
<td>In Progress</td>
<td>9 Establish Board and Committee Meeting Schedules</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 10</td>
<td>In Progress</td>
<td>10 Determine ACP operational locations</td>
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<td>09/30/2015</td>
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<tr>
<td>Establish a clinical governance structure, including clinical quality committees for each DSRIP project</td>
<td>In Progress</td>
<td>This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
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### New York State Department Of Health
### Delivery System Reform Incentive Payment Project
### DSRIP Implementation Plan Project

**Advocate Community Providers, Inc.** (PPS ID:25)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
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<th>Quarter</th>
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<tr>
<td>Task 1 Appoint CMO</td>
<td>Completed</td>
<td>1 Appoint Chief Medical Officer, Jackson Kuan, MD</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015DY1 Q1</td>
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<td>Task 2 Clinical Quality Committees</td>
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<td>2 Establish clinical quality committees for each project</td>
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<td>06/30/2015</td>
<td>06/30/2015DY1 Q1</td>
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<td>Task 3 Evidence-Based Protocols</td>
<td>Completed</td>
<td>3 Establish and distribute evidence-based clinical protocols and processes</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015DY1 Q1</td>
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<td>Task 4 Procedure Manual</td>
<td>In Progress</td>
<td>4 Create and distribute process and procedure manuals for compliance</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015DY1 Q2</td>
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<tr>
<td>Task 5 Physician Engagement Teams</td>
<td>In Progress</td>
<td>5 Establish physician engagement teams to monitor adherence to protocols and workflow processes. The physician engagement teams include members from the communities in which the physicians serve. They are culturally and linguistically competent therefore understand the culture of the communities and can provide assistance and support to the physicians in the implementation of the projects in a way that is most efficient.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015DY1 Q2</td>
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<tr>
<td>Task 6 Performance Reporting Metrics</td>
<td>In Progress</td>
<td>6 Create and adopt Performance reporting Metrics. These performance metrics are developed from industry and evidence based monitoring standards which reveal not only when a patient is engaged, but also the timeliness and effectiveness of the interventions. These metrics include such values as, Hgb a1c levels to demonstrate effectiveness of hypoglycemic therapy, Monitoring BP levels, Flow sheets demonstrating episodic treatments and exacerbations, Rates of hospital utilizations and trending of these values to show progression or control and enhanced performance and outcome.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015DY1 Q2</td>
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<tr>
<td>Task 7 PAC and Care Team Roles</td>
<td>Completed</td>
<td>7 Confirm PAC and Care Team members and establish defined roles for each. The PAC serves in ACP as a true advisory committee, reviewing processes and protocols and providing ACP’s Project Management Office with input on efficacy of same. ACP’s PAC represents and communicates the voice of its over 200 partners. The PAC is made up of ACP partners from all different provider types and they are part of the ACP Care Teams which they then serve to represent before the PMO. They bring the voice of the partners as well as the feedback on processes, which they also assist in creating. The Care Teams are regional and are made up of all ACP partners of all provider types within a geographical area. The Care Teams are the “ground troops” of ACP. They are the partners committed to providing care to ACP’s patients in accordance with the ACP established protocols and processes.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015DY1 Q1</td>
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<tr>
<td>Task 8 Meeting Schedules</td>
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<td>8 Establish committee meeting schedules</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015DY1 Q1</td>
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<td>Milestone #3</td>
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<td>This milestone must be completed by 9/30/2015. Upload of bylaws and</td>
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<td>09/30/2015</td>
<td>09/30/2015DY1 Q2</td>
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<tr>
<td>Finalize bylaws and policies or Committee Guidelines where applicable</td>
<td></td>
<td>policies document or committee guidelines.</td>
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<tr>
<td>Task 1 Approve bylaws</td>
<td>Completed</td>
<td>1 Board of Directors will approve bylaws which shall be adopted immediately</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
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<tr>
<td>Task 2 Appoint Compliance Officer</td>
<td>Completed</td>
<td>2 Appoint Compliance Officer and Communicate Compliance Policies and Procedures</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
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<tr>
<td>Task 3 Adopt Key Corporate Compliance Policies</td>
<td>Completed</td>
<td>3 Compliance Officer and committee will develop and Adopt Key Corporate Policies and Procedures including but not limited to: Code of ethics, Conflict of interest, compliance, document destruction and Retention, HR policies and procedures, HIPAA, whistleblower policy.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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<tr>
<td>Task 4 Dispute Resolution Policies</td>
<td>In Progress</td>
<td>4 Board, compliance officer, and in-house attorney will draft and Adopt Dispute Resolution Policies and Procedures. If there is a conflict among partners, stakeholders or within any committees, the Board will make a determination after considering the facts and feedback from such partners and stakeholders. Depending on the nature of the issue, the issue may be submitted to one of the functional committees (i.e., clinical, finance, HIT, audit, and compliance committees) if the issue falls within the scope of any such committee, or a special subcommittee of the Steering Committee or the PAC.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 5 Provider Performance Policies</td>
<td>In Progress</td>
<td>5 Board, compliance officer and in-house attorney shall draft and Adopt Underperforming Provider Policies and Procedures and include them in the Provider Contracts</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 6 Committee Guidelines</td>
<td>In Progress</td>
<td>6 Develop Committee guidelines for each committee</td>
<td>04/01/2015</td>
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<tr>
<td>Milestone #4 Establish governance structure reporting and monitoring processes</td>
<td>In Progress</td>
<td>This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td>Task 1 Analytics Team</td>
<td>In Progress</td>
<td>1 Create Analytics team for pulling metrics, creating reports and providing analysis to present to clinical management</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 2 Clinical Quality Team Roles</td>
<td>In Progress</td>
<td>2 Define roles of Clinical Quality Committee in monitoring and reporting</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 3 Identify Performance Metrics</td>
<td>In Progress</td>
<td>3 Identify and Select Key Metrics to Assess Achievement/Engagement performance. These metrics will include analysis of patients achieving target goals and those not, number of patients engaged using internal reporting codes pulled from EMR and practice management systems, measurement of avoidable hospital utilizations based on PPS developed algorithms that use predictive measures such as length of hospital stay/ICD/number of episodes, and others. Performance of the governing committees will also be</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td><strong>Task 4 Collecting and Reporting Data</strong></td>
<td>In Progress</td>
<td>4 Develop Tools for Collecting and Reporting Data from all Participating Providers and Communicating Results. These tools will include homegrown reporting codes that are posted at encounters, use of registries, MCO reports, laboratory test result values, amongst others.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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<td><strong>Task 5 Reporting Schedule</strong></td>
<td>In Progress</td>
<td>5 Establish reporting periodicity. The PPS foresees a monthly reporting schedule</td>
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<td><strong>Task 6 Reporting Baselines and Thresholds</strong></td>
<td>Completed</td>
<td>6 Establish baselines and thresholds to measure provider performance and implement corrective action plan implementation needs</td>
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<td><strong>Task 7 Corrective Action Plan</strong></td>
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<td>7 Develop a provider corrective action plans and penalty/reward system to be implemented by provider quality control and communications committee</td>
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<td><strong>Task 8 Reporting Workflows</strong></td>
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<td>8 Establish upstream information workflow processes (information from providers to PPS)</td>
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<td><strong>Task 9 Oversight Authority</strong></td>
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<td>9 Determine oversight authority for implementation of corrective action</td>
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<td><strong>Milestone #5</strong></td>
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<td>Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)</td>
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<td>09/30/2015</td>
<td>09/30/2015</td>
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<td><strong>Task 1 Community Engagement</strong></td>
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<td>1 Establish community engagement unit hire unit director and Manager of Community Health Worker Program.</td>
<td>04/01/2015</td>
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<td><strong>Task 2 Establish Communications Committee</strong></td>
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<td>2 Establish Communications committee and hire and engage a communications/public relations firm with experience in health care.</td>
<td>04/01/2015</td>
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<tr>
<td>Task 3 Messaging</td>
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<td>3 Conduct messaging exercise</td>
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<td>07/31/2015</td>
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<td>Task 4 Finalize Communications Plan</td>
<td>In Progress</td>
<td>4 Finalize Communications Plan in accordance with DSRIP guidelines</td>
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<td>07/31/2015</td>
<td>09/30/2015</td>
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<td>Task 5 Communications Plan</td>
<td>In Progress</td>
<td>5 Provide draft of community engagement plan. The plan includes the following components: definition of the role that neighborhood based medical practices will play within the overall community engagement plan; plan to conduct outreach to patients within the community that may not be in contact with primary care physicians; Identification of major/local engagement events to include engagement through educational activities such as health fairs and Stanford Model educational meetings/seminars, amongst others; plans for media outreach (including local and ethnic Media); schedule of outreach efforts to key elected and appointed officials; CBO outreach and engagement plan and schedule; public and non-provider organizations engagement plan; Outreach to community and school boards and local health department offices; and Recruitment, training and deployment of CHWs as a major component of the overall plan to engage the community. This engagement will insure our ability to reach patients in their own culture and neighborhood, increase health literacy, and allow patients access to more efficient care and preventative services.</td>
<td>08/01/2015</td>
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<tr>
<td>Task 6 Finalize Schedule</td>
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<td>6 Finalize monthly schedule of engagement activities/events</td>
<td>07/01/2015</td>
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<td>Task 7 Steering Committee Review</td>
<td>In Progress</td>
<td>7 Submit final draft of the community engagement plan to Steering Committee for input and governance board for review and approval.</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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<td>Milestone #6</td>
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<td>Signed CBO partnership agreements or contracts.</td>
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<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td>Task 1 Establish CBO Proposal</td>
<td>In Progress</td>
<td>1 Working closely with partners and selected leaders of major CBOs, ACP staff under the division of Workforce, Community and Government Relations will develop a &quot;Proposal to Establish the CBO Partnership Program&quot; (CBOPP) for collaborating on outreach and organizing, patient engagement and education, community health workers, and cultural competence and health literacy training. Once proposal is approved by Senior Management, staff initiates implementation.</td>
<td>08/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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<td>Task 2 Expression of Interest Request</td>
<td>In Progress</td>
<td>2 The partnership development process begins with the issuance of A request for An Expression of Interest (EI). The request for an EI is circulated amongst key CBOs throughout the target area on an invitational basis. A number of</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<td><strong>Task 3 Review EI Responses</strong></td>
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<td>3</td>
<td>In Progress</td>
<td>3 ACP staff reviews responses to the EI and works with the pre-selected CBOs to draft contractual agreements delineating areas of collaboration. An Ad Hoc Committee composed of Board and Steering Committee members is created to review and finalize agreements with CBOs based on staff recommendations. The agreements clearly define project objectives and a plan to monitor and evaluate activities and outcomes.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<td><strong>Task 4 Execute Agreement and Training</strong></td>
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<td>4</td>
<td>In Progress</td>
<td>4 Contractual agreements with CBOs are executed and staff provide training, oversight and guidance.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td><strong>Milestone #7</strong></td>
<td></td>
<td>Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)</td>
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<td>In Progress</td>
<td>Agency Coordination Plan.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Task 1 Identify Local Support Agencies</strong></td>
<td>In Progress</td>
<td>1 Through the CNA process ACP identified several agencies including local neighborhood, state and city that can afford services to its patients to better help in the implementation of treatment plans and to improve patient's health and health literacy. These agencies include the New York City department of health and mental hygiene, NYC Department of Education, NY QUITTS, and the NYC HRA among others. ACP also has relationships and partners that it is leveraging such as with Office of Mental Health, and organizations of people with disability such as Federation of Organizations for NYS Mentally Disabled Through its relationship with these and other agencies ACP will coordinate patient care and education. Some of these agencies represented on the PAC, Clinical Quality Committees as well as the Care Teams. ACP will identify and select all pertinent state and local public sector agencies that will assist in providing services to ACP patients including housing, tobacco cessation, in school treatment plans, etc.</td>
<td>04/01/2015</td>
<td>07/31/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 2 Develop an ACP Public Agency Coordination Plan</td>
<td>In Progress</td>
<td>2 Establish division for Workforce, Community and Government Relations; appoint Division Director.</td>
<td>04/01/2015</td>
<td>07/31/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 3 CBO Liaison</td>
<td>In Progress</td>
<td>3 Identify staff (liaison) responsible for coordinating with public sector agencies; coordinate plan development activities with the PAC.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 4 Review ACP Public Agency Coordination Plan</td>
<td>In Progress</td>
<td>4 Draft report identifying public sector agencies that will assist in providing services to ACP patients. The report will include information about the services to be provided, the roles and responsibilities of key public sector agencies within DSRIP.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 5 Finalize ACP Public Agency Coordination Plan</td>
<td>In Progress</td>
<td>5 Finalize plan to execute collaborative agreements with public sector agencies. Such agreements will include process and procedures for the exchange of information including patient specific information in accordance with HIPPA regulations, process and procedures for client referrals, opportunities for joint planning including involvement in Advisory Committees whenever possible, collaboration around domain 4 initiatives, opportunities for training around a wide range of issues including cultural competency and health literacy, involvement in joint community engagement activities and events, and participation in public/community events.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 6 Submit Agency Coordination Plan</td>
<td>In Progress</td>
<td>6 Submit agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels to Steering Committee for input and governing board for review and approval.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Milestone #8 Inclusion of CBOs in PPS Implementation</td>
<td>In Progress</td>
<td>Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
<td>NO</td>
</tr>
<tr>
<td>Task 1 Identify CBOs</td>
<td>In Progress</td>
<td>1 Identify CBOs in network, determine gaps in network (service-level and geographic level), determine capabilities for integration and review/execute PPS agreements with CBOs. Network CBOs, such as God's Love We Deliver, a meals delivery organization; Catholic Charities which has several branches providing housing and social services; local YM/WHA, which provides services to seniors and children; NY QUITs; City Department of health and mental hygiene; Department of Education and many others will be part of the milestone. However, there are still others that ACP will be reaching out to further increase its reach to ACP’s vast network of patients, providers and geographical area.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 2 Establish Roles</td>
<td>In Progress</td>
<td>2 Establish roles for each CBO. CBOs provide a wide variety of services. Important to convey expected roles for each so that PPS service delivery is</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
</tbody>
</table>
### Advocate Community Providers, Inc. (PPS ID:25)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task 3 System Integration</strong></td>
<td>In Progress</td>
<td>3 Based on capabilities, establish plan to integrate CBOs. Ideal state is CBO has robust system that can fully integrate with PPS HIE and/or care management system. If system will not be compatible for integration (ie paper, limited technology), workflows will be developed to ensure effective communication with feedback loop are present. Adequate support will be evaluated at the individual CBO level.</td>
<td>01/01/2016</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Milestone #9 Finalize workforce communication and engagement plan</strong></td>
<td>In Progress</td>
<td>Workforce communication &amp; engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).</td>
<td>09/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Task 1 Workforce Communication and Engagement Strategy</strong></td>
<td>In Progress</td>
<td>1 Establish a working group of the Workforce Committee to develop a comprehensive Workforce Communication and Engagement Strategy based on PPS Communication Plan; subcommittee includes labor representatives.</td>
<td>09/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td><strong>Task 2 Workforce Communication and Engagement Plan</strong></td>
<td>In Progress</td>
<td>2 The subcommittee finalizes a draft of the Workforce Communication and Engagement Plan; the plan will include strategies for communications about job requirements, training opportunities, and advancement opportunities to all pertinent staff; strategies for partners to communicate changes in the workforce at the partner level-training and retraining needs as well as new hires to Workforce Department for consistency in reporting, training and staff development; utilize a broad range of media from print to the internet and the ACP website, to text and emails as well as the media at large; the plan will communicate information regarding ACP, DSRIP; job training and growth opportunities, employment availability postings and other job and employment related issues; the plan will be interactive and include opportunities for two-way communication with the workforce.</td>
<td>10/01/2015</td>
<td>10/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task 3 Workforce Review</strong></td>
<td>In Progress</td>
<td>3 The plan is presented to and reviewed by selected members of the workforce for additional input.</td>
<td>11/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task 4 Final Approval</strong></td>
<td>In Progress</td>
<td>4 Final draft of the plan is presented to the Steering Committee and the PPS Governance Board for final approval.</td>
<td>12/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task 5 Review and Approve Communication Plan</strong></td>
<td>In Progress</td>
<td>5 Communication plan is reviewed and approved by Governing Board.</td>
<td>12/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
</tbody>
</table>

### Prescribed Milestones Current File Uploads

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
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</tr>
</tbody>
</table>

NYS Confidentiality – High
### Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalize governance structure and sub-committee structure</td>
<td></td>
</tr>
<tr>
<td>Establish a clinical governance structure, including clinical quality committees for each DSRIP project</td>
<td></td>
</tr>
<tr>
<td>Finalize bylaws and policies or Committee Guidelines where applicable</td>
<td></td>
</tr>
<tr>
<td>Establish governance structure reporting and monitoring processes</td>
<td></td>
</tr>
<tr>
<td>Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)</td>
<td></td>
</tr>
<tr>
<td>Finalize partnership agreements or contracts with CBOs</td>
<td></td>
</tr>
<tr>
<td>Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)</td>
<td></td>
</tr>
<tr>
<td>Finalize workforce communication and engagement plan</td>
<td></td>
</tr>
<tr>
<td>Inclusion of CBOs in PPS Implementation.</td>
<td></td>
</tr>
</tbody>
</table>
IPQR Module 2.2 - PPS Defined Milestones

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
</table>
| 1 Inclusion of CBOs | In Progress  | Working with existing CBO network partners (such as RAIN, East Harlem HELP, God's Love We Deliver, Samaritan Village, Narco Freedom, Catholic Charities, YM/WHA) and selected leaders of major CBOs (such as the Hispanic Federation, the Federation of Protestant and Welfare Agencies, The NY Immigration Coalition, the Association of Black Executive Directors and others) ACP staff under the division of Workforce, Community and Government Relations will develop a "Proposal to Establish the CBO Partnership Program" (CBOPP). CBOPP was designed in order to insure that CBOs play an important role in the development of ACP. The CBOPP program will carve out roles for CBOs within ACP to include but not be limited to: • Service delivery; • Outreach and organizing; • Patient engagement and education; • Deployment of community health workers; • Cultural competence and health literacy training; • Community organizing and mobilization

Once solicitation instruments are approved by Senior Management, staff initiate implementation activities.

A request for An Expression of Interest (EI) is circulated to key CBOs throughout the target area on an invitational basis.

A sub-Committee of the Workforce Committee composed of Board and Steering Committee members is created to review and finalize agreements with CBOs based on staff recommendations.

The agreements clearly define project objectives and a plan to monitor and evaluate activities and outcomes. | 04/01/2015 | 03/30/2016 | 03/31/2016 | DY1 Q4 |
## Contractual agreements with CBOs are executed and staff provide oversight, training and guidance.

ACP expects to contract with 10-20 CBOs with a special emphasis on "Hotspots" by DY1, Q4.

### PPS Defined Milestones Current File Uploads

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
</table>

No Records Found

### PPS Defined Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Inclusion of CBOs</td>
<td></td>
</tr>
</tbody>
</table>
IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions:

Please describe the key challenges or risks that you foresee in implementing your governance structure and processes and achieving the milestones described above, as well as potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Time Commitment: to be successful we need dedicated people who are knowledgeable and who will attend meetings regularly and provide their best advice and judgment. ACP has the unique identity of being a physician-led PPS. While ACP comprises many other types of providers including but not limited to significant hospital partners, it needs to have physicians, particularly PCPs, at the helm to stay true to its identity. Physician providers who have been selected to participate in governance are busy with their practices and/or other activities. We are asking them to make a significant commitment-- to volunteer substantial amount of time serving on the Board and/or Committees and Workgroups. There is a risk that they will burn out and lose their motivation over the five years of the program. We hope this is not the case but must be prepared by developing a backup set of community physician leaders, champions and influencers who are engaged and aligned to the PPS goals and objectives and who are willing to step into the seat of governance should they be needed. DSRIP is complex evolving program that requires significant study and knowledge for the Board and Committees to make appropriate decisions. There is a risk that physicians may not have the necessary knowledge about DSRIP goals and objectives to be effective decision-makers. They may also not be aware of their obligations as members of nonprofit governing structures. Notwithstanding these considerations we understand that medical practices across all PPSs will face similar challenges. To mitigate potential risk ACP will develop various educational and training programs. There is a risk that Board members become overwhelmed by information and the complexity of the DSRIP program workstreams and projects. To mitigate this we look to provide the board with concise and specific information in the form of a Dashboard for effective and efficient decision-making.

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions:

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

All of the work streams are Interdependent and dependent on governance. The Board and Committees have an overarching role to play in each of the work streams. The board, committees, PAC Leadership Council provide guidance with respect to all of the work flows. While the board and committees do not manage the work streams themselves, they have a role in overseeing management and the work stream processes and progress. They have a keen interest in the Workforce work stream and a direct fiduciary interest in the budget and funds flow work streams.
**IPQR Module 2.5 - Roles and Responsibilities**

Instructions:

Please list and elaborate upon the key people/organizations responsible for the development of your governance structure and processes and describe what their responsibilities involve.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Applicant</td>
<td>Advocate Community Partners (CEO: Mario Paredes)</td>
<td>Governance, Staffing, Funding</td>
</tr>
<tr>
<td>Physician Organizations</td>
<td>NYCPP, FQHC, ACOs, IPAs</td>
<td>Board and Committee Representation, Develop and approve EBM protocols and provide service to Medicaid recipients</td>
</tr>
<tr>
<td>Major Hospital Partners</td>
<td>NSLIJ, Medisys</td>
<td>Board and Committee Representation, Funding</td>
</tr>
<tr>
<td>Major CBOs</td>
<td>Several</td>
<td>Provide intervention services as necessary and education to ACP patients</td>
</tr>
<tr>
<td>Social Services Agencies</td>
<td>Several</td>
<td>Feedback, Representation, Patient engagement and intervention, providing necessary services</td>
</tr>
<tr>
<td>Key Advisors</td>
<td>Joe DeMarzo- In house counsel, Tom Hoering-Compliance Officer</td>
<td>Create Governance Documents, compliance documents, provider agreements, policies and procedures</td>
</tr>
</tbody>
</table>
Module 2.6 - IPQR Module 2.6 - Key Stakeholders

Instructions:
Please identify the key stakeholders involved, both within and outside the PPS with regard to your governance structure and processes.

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AW Medical Board of Directors</td>
<td>Governance</td>
<td>Finalized governance document, approved contractual agreements/PPS fiscal &amp; programmatic oversight</td>
</tr>
<tr>
<td>NYPCC</td>
<td>Governance</td>
<td>Funding, governance, operational staff</td>
</tr>
<tr>
<td>NSLIJ Fiduciary</td>
<td>Fiduciary</td>
<td>Timely disbursal of funds/internal controls</td>
</tr>
<tr>
<td>Medisys Key Hospital Partner, Non-voting Member of ACP</td>
<td>Key Hospital Partner, Non-voting Member of ACP</td>
<td>Provide critical input/participate in deliberations of governing body</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAC Leadership Council</td>
<td>Provide critical input to Project Management on implementation and performance of all projects</td>
<td>Review and advise on processes and procedures as related to project development and implementation</td>
</tr>
<tr>
<td>Labor Unions (Helen Schaub)</td>
<td>Workforce</td>
<td>Participate Workforce issues, agreements and documents,</td>
</tr>
<tr>
<td>Community Organizations</td>
<td>Engage patients and provide services within the community in culturally sensitive manner</td>
<td>Deliver services to ACP patients, liaise within community, provide patient education</td>
</tr>
<tr>
<td>Religious Organizations</td>
<td>Contribute to community engagement, health literacy, patient outreach</td>
<td>Service delivery/Advice and advocacy. Site availability</td>
</tr>
<tr>
<td>Elected Officials</td>
<td>Community outreach and advisory</td>
<td>Advice and advocacy</td>
</tr>
<tr>
<td>NYS DOH, CMS, KPMG, IA</td>
<td>Key DSRIP Program Administrators</td>
<td>Funding; Timely responses to PPS queries and requests/Monitoring, Support, Technical assistance</td>
</tr>
<tr>
<td>State and City organizations, NYC Dept of Health and Mental Hygiene, NY QUITS,</td>
<td>Learning Collaborative, collaborate in patient services</td>
<td>Share best practices, provide input on service efficacy, help coordinate collaboration amongst PPS'</td>
</tr>
<tr>
<td>Other PPS Organizations</td>
<td>Learning Collaborative, collaborate in patient services</td>
<td>Provide services to common patients and report on treatment records, Share best practices</td>
</tr>
<tr>
<td>TEF (Sandi Vito)</td>
<td>Workforce Training and Redeployment</td>
<td>Participate on Workforce Training and Redeployment issues, agreements and documents</td>
</tr>
</tbody>
</table>
IPQR Module 2.7 - IT Expectations

Instructions:

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream and your ability to achieve the milestones described above.

The development and implementation of ACP’s IT Strategy including shared services and infrastructures will assist the Board of Directors with relevant data collected from all participating providers to support effective decision and formulation of operational strategies. The IT platform shall be upstream and downstream of information allowing for metric pulls and data analysis that will be used for performance evaluations using set baselines against DSRIP commitments and goals. The platform will include alerts and structure to ensure compliance and adherence to set processes as approved by the governing bodies.

Accurate information and data will provide for transparency and objective decisions making process and reports for the Board of Directors and other governance committees and sub-committees such as Financial, Clinical, IT, etc. Decisions based on relevant and timely data will form the bases for building and maintaining trusting relationships and credibility with stakeholders including participating providers, partners, the public at large and most importantly, the population that will be served by the PPS. We envision the development and launch of a Partner Portal/Intranet solution where all partners can track progress, and report activities against set milestones and goals. Furthermore, the provider portal/intranet will be an efficient communications channel for collaboration and ongoing discussion of issues and activities impacting governance of the ACP PPS and offers a direct communications channel from the participating partners to the Board of Directors, executive staff and other governance entities.

IPQR Module 2.8 - Progress Reporting

Instructions:

Please describe how you will measure the success of this organizational workstream.

We look to create and adopt a dashboard with insightful data presented in an attractive format that informs and brings greater clarity to collective decision-making and reporting. While staff often track many metrics as part of a broader performance management system, Boards do not want to be overwhelmed with information. Therefore, the best governance dashboards use as few metrics as possible to communicate the organization's performance and progress against key initiatives. It can be as simple as indicating the targets and indicating whether or not ACP is meeting the targets. Nonprofit dashboards that use Green, Yellow and Red indicators demonstrate one simple way to let the board know if the organization is on track in terms of progress against key initiatives, including but not limited to, achieving the milestones laid out for ACP such as creating the governance structure, recruiting and filling the board and committee positions, developing and adopting bylaws, policies and procedures, contracting with CBOs and other key participants and others. The key is to get the board's attention on asking the right questions. The success of the board depends on its ability to make sound judgments in situations that involve balancing the competing interests of different stakeholders while delivering on key milestone results. Best practice governance embraces the 'CRAFTED' principles of governance: a culture and a climate of Consistency, Responsibility, Accountability, Fairness, Transparency, and Effectiveness that is deployed throughout the entire organization.
Numerous governance rating models exist. We look to use or develop a model that not only looks at structural aspects of governance, such as the composition of the board and committees, but also aspects such as the decision-making process, the quality of information, and the results of oversight and guidance functions of the board of directors. ACP will build an organizational dashboard to standardize the tracking of ACP performance in terms of key measures of performance and outcomes. We will look to capture objectives, inputs, outputs, intermediate outcomes (benchmarks), final outcomes and performance indicators. The dashboard will show both current status (snapshot) and progress in terms of trends. Such reporting will include: attendees in meetings, meeting minutes, decision points suggested or made, and reporting to show approvals of outstanding committee or board meetings, etc. We will look to capture information to report on all of the work streams and projects. ACP has developed and is developing several reporting and monitoring metrics as well as clinical quality measures that will be used to monitor success of the clinical and related work streams. Appropriately engaging and systematically communicating with stakeholders is important to the successful design and implementation of the governance plan. The participation and acceptance of key stakeholder groups is crucial in developing a system that is supported by the larger community and likely to be sustained. Ongoing and targeted communication between project leaders and stakeholder groups is critical to ensure programmatic success. Implementing value-based, performance-pay and risk-based systems is a way of securing continued interest, buy-in and sustainability of transformation. Commitment to a new compensation system is essential to a program's success as well as its long-term sustainability.

**IPQR Module 2.9 - IA Monitoring**

**Instructions :**
### Section 03 – Financial Stability

**IPQR Module 3.1 - Prescribed Milestones**

**Instructions:**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.

Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

<table>
<thead>
<tr>
<th>Milestone(Task) Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
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</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalize PPS finance structure, including reporting structure</td>
<td>In Progress</td>
<td>This milestone must be completed by 12/31/2015. PPS finance structure chart/document, signed off by PPS Board.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>YES</td>
</tr>
<tr>
<td>Task 1 Identify Leadership</td>
<td>Completed</td>
<td>1 Identify and hire CFO</td>
<td>07/01/2015</td>
<td>07/31/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 2 Finance Charter</td>
<td>In Progress</td>
<td>2 Define roles and responsibilities of Finance team (i.e. Charter), including reporting structure/completion of org chart.</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 3 Staffing Needs</td>
<td>In Progress</td>
<td>3 Define staffing needs, roles and responsibilities</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 4 Hire Staff</td>
<td>In Progress</td>
<td>4 Identify and hire Finance Directors and other support staff</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 5 Finalize Fiduciary Agreement</td>
<td>In Progress</td>
<td>5 Define duties of fiduciary (NSLL) including policies, structure and fees</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 6 Finance Committee</td>
<td>In Progress</td>
<td>6 Identify members of the Finance Committee</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 7 Establish Policies and Procedures</td>
<td>In Progress</td>
<td>7 Establish policies and procedures regarding: - Funds flow - Accounting (selection of software, system) - Budget process, including orders and requests</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 8 Board Approval</td>
<td>In Progress</td>
<td>8 Obtain Board approval for proposed Finance functions.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
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<tr>
<td><strong>Milestone #2</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.</td>
<td>In Progress</td>
<td>This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>YES</td>
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<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
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<tr>
<td>Task 1 DSRIP</td>
<td>Completed</td>
<td>1 Determine reporting requirements as defined by DSRIP guidelines regarding financial sustainability</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
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<tr>
<td>Task 2 Create</td>
<td>In Progress</td>
<td>2 Create Financial Sustainability Survey to assess current state of PPS providers</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 3 Determine</td>
<td>In Progress</td>
<td>3 Determine criteria of what defines financially fragile providers and create policies and procedures that include support of these providers</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 4 Assess</td>
<td>In Progress</td>
<td>4 Assess impact of projects in terms of implementation costs (training, in-servicing, etc.) and business impacts (reduction of inpatient services).</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 5 Develop</td>
<td>In Progress</td>
<td>5 Develop financial stability strategies for those at risk partners</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
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<tr>
<td>Task 6 Hire</td>
<td>In Progress</td>
<td>6 Hire staff (financial analyst) dedicated to collecting and monitoring providers and financial stability measures</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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</tr>
<tr>
<td>Task 7 Complete</td>
<td>In Progress</td>
<td>7 Complete assessment (analyze results, identify providers at risk, identify providers who are recipients of the IAAF). Determine next steps with at-risk providers including understanding of drivers of financial instability and assistance with revenue stream improvement. Propose potential PPS support including:</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 8 Develop</td>
<td>In Progress</td>
<td>8 Develop an annual schedule to monitor financial sustainability of providers (more frequently if provider is considered financially fragile)</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 9 Board</td>
<td>In Progress</td>
<td>9 8 Obtain Board approval for proposed Financial Sustainability strategy</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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</tr>
<tr>
<td>Task 9 Continue</td>
<td>In Progress</td>
<td>9 Continue with sustainability monitoring based on annual schedule, for financially fragile providers</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>Milestone #3</td>
<td>In Progress</td>
<td>Finalize Compliance Plan consistent with New York State Social Services Law 363-d. This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 1 Draft</td>
<td>Completed</td>
<td>1 Identify and retain proper counsel to draft compliance plan consistent with 363-d, including written policies and procedures that includes all required elements (code of conduct, training and education program, communication)</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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Advocate Community Providers, Inc. (PPS ID:25)

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<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
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<tbody>
<tr>
<td>Task 2 Approve Plan</td>
<td>In Progress</td>
<td>2 Approve plan and execute on deliverables required by such plan</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td>Task 3 Reporting Needs</td>
<td>In Progress</td>
<td>3 Engage IT to configure system that meets compliance plan’s reporting needs</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 4 Plan for Non-Compliance</td>
<td>In Progress</td>
<td>4 Develop process that addresses providers who do not meet compliance requirements, including Corrective Action Plans that will assist with meeting compliance.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 5 Compliance Officer</td>
<td>Completed</td>
<td>5 Appoint Compliance Officer</td>
<td>04/01/2015</td>
<td>04/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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<tr>
<td>Task 6 Compliance Meeting Schedule</td>
<td>In Progress</td>
<td>6 Implement frequent meetings between Compliance Officer and Board to ensure plan is effective and maintained.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 7 Training</td>
<td>In Progress</td>
<td>7 Provide recurring training that satisfies requirements.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Milestone #4</td>
<td>In Progress</td>
<td>This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>YES</td>
</tr>
<tr>
<td>Task 1 Leverage Existing Relationships w MCOs and Develop VBP Transition Plan</td>
<td>In Progress</td>
<td>1 Leverage PPS relationships with MCOs already in place for value based payments. Present, educate and align PPS providers to value-based payment methodologies and partner with MCOs to develop value-based payment plans - Introduce value-based concept and perform a survey to engage providers, including performance tiering and establish expectations - Perform analysis of revenue as well as expense models (revenue: understand appropriate loss ratio targets based on Medicaid premium, potential admin and care management costs, and costs of other impacts such as workforce impact, and expense: expected expense thresholds in provider settings, expected expense targets for MCO's to determine revenue targets) - Establish detailed baseline based on current utilization and model outcomes - Establish roles and expectations for each participating provider - Monitor funds flow</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tbody>
<tr>
<td><strong>Task 2 Establish Data Feeds</strong></td>
<td>In Progress</td>
<td>2 Establish appropriate and recurring data feeds from MCOs to monitor revenue and expense trends (cost and utilization). Establish value initiatives that improve or target highlighted trends.</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task 3 Engage MCO for PPS Performance</strong></td>
<td>In Progress</td>
<td>3 Engage with MCOs to identify (timely) PPS performance at all levels, engage partners to ensure that plan is satisfactory and considers concerns that are raised. Performance includes medical expense trends and care gaps, amongst others.</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task 4 Reporting</strong></td>
<td>In Progress</td>
<td>4 Create reporting from MCO data at appropriate detail levels (by provider, by region/county) for management review and distribution to providers.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task 5 Performance Grading</strong></td>
<td>In Progress</td>
<td>5 Develop methodology to 'grade' providers - establish guidelines for surplus sharing based on provider type. Conversely, establish mitigation plans if providers are in deficit.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task 6 Provide Support</strong></td>
<td>In Progress</td>
<td>6 Ensure adequate support for providers throughout entire process, including monthly meetings to discuss performance and mitigation steps if performance is negative. Support includes: Provider Engagement Outreach Team, education and training, standard reporting definitions, etc.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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</tr>
<tr>
<td><strong>Task 7 Underperforming Provider Support</strong></td>
<td>In Progress</td>
<td>7 Develop action plan to support providers unable to perform under value-based system. At this point, providers have been educated about VBP plan and transition timeline (see step 1), provided reports, expectations and actionable steps, and presented a support structure.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task 8 Corrective Action Plans</strong></td>
<td>In Progress</td>
<td>8 Establish corrective action plan for treatment of providers unable to improve performance.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task 9 Board Approval</strong></td>
<td>In Progress</td>
<td>9 Appropriate Board approval of all proposed policies and procedures.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest</strong></td>
<td>In Progress</td>
<td>This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board.</td>
<td>01/01/2016</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Task 1 VBP Plan</strong></td>
<td>In Progress</td>
<td>1 Develop VBP plan with input from MCO, providers, and key stakeholders and determine approach for PPS in its entirety (IPC vs bundles of care vs subpopulation risk) including ramp-up steps until Level III VBP is achieved. Plan includes milestones such as time frame for each value-based approach, ultimately achieving value-based payments that are 90% of total payments to providers. Plan includes: - Understanding of provider capabilities and knowledge of value based.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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## New York State Department Of Health
### Delivery System Reform Incentive Payment Project
#### DSRIP Implementation Plan Project

**Advocate Community Providers, Inc.  (PPS ID:25)**

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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td><strong>Task 2 Engage MCOs</strong></td>
<td>In Progress</td>
<td>2 Engage MCOs with VBP plan to gauge feasibility of plan implementation within MCO system, establish appropriate data feeds, and reporting requirements. Leverage MCO expertise and resources (actuarial, contracting, provider outreach) to assist with transition include metric development and communication with providers.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task 3 Provider Engagement and Adoption</strong></td>
<td>In Progress</td>
<td>3 Establish roll-out plan for provider engagement and adoption. Introduce plan to providers in PPS, specifying roles of all provider types and those considered safety-net vs non-safety net.</td>
<td>04/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Task 4 Establish Reporting Set</strong></td>
<td>In Progress</td>
<td>4 Develop robust reporting set so providers can monitor their performance at all levels (provider, group, county, etc.) and develop actionable items to positively impact trends, where necessary. Also develop plan to assist providers who are in 'deficit' or where performance doesn't allow for value-based payments.</td>
<td>04/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td><strong>Task 5 Board Approval</strong></td>
<td>In Progress</td>
<td>5 Finalize and acquire Board approval for VBP plan for PPS. Plan to include scope, provider type at risk, expectations, metrics required and reporting requirements.</td>
<td>07/01/2016</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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<tr>
<td><strong>Milestone #6</strong></td>
<td>On Hold</td>
<td>Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td><strong>Milestone #7</strong></td>
<td>On Hold</td>
<td>Contract 50% of care-costs through Level 1 VBPs, and &gt;= 30% of these costs through Level 2 VBPs or higher</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

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<tr>
<td>Milestone #8</td>
<td>On Hold</td>
<td>&gt;=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and &gt;= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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Prescribed Milestones Current File Uploads

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Prescribed Milestones Narrative Text

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<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>Finalize PPS finance structure, including reporting structure</td>
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<tr>
<td>Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.</td>
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<tr>
<td>Finalize Compliance Plan consistent with New York State Social Services Law 363-d</td>
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<tr>
<td>Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.</td>
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<tr>
<td>Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest</td>
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<tr>
<td>Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation</td>
<td></td>
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<tr>
<td>Contract 50% of care-costs through Level 1 VBPs, and &gt;= 30% of these costs through Level 2 VBPs or higher</td>
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NYS Confidentiality – High
Advocate Community Providers, Inc. (PPS ID:25)

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<tr>
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<tr>
<td>&gt;=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBP's, and &gt;= 70% of total costs captured in VBP's has to be in Level 2 VBP's or higher</td>
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### IPQR Module 3.2 - PPS Defined Milestones

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

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### PPS Defined Milestones Current File Uploads

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### PPS Defined Milestones Narrative Text

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IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions:

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

Financial Instability: some providers may face financial instability throughout the DSRIP period from decreased operational revenue (reduced admissions) or increased administrative expenses through involved process changes. These could be mitigated by the PPS's proposed funds flow (in the case of decreased operational revenue) or centralized systems and support (care management, IT staff for PCMH and integration) that would assist providers achieve efficiency (in the case of increased administrative expenses).

Cash Flow: there could be cash flow issues due to wide seasonality in utilization with our population that we serve. There are often high expenses in certain time periods (flu season, back-to-school time) where expenses spike which could reduce payouts to physicians once VBP programs are in place. Reserve strategies or alternate contracting terms addressing seasonality could play a role in helping physicians.

Data and Analytics: Because VBP is heavily based on data and analytics, the accuracy and timely delivery and processing of data could pose additional dependency risks. Delays in data process and within reporting process could have set-backs in trying to achieve VBP. Also, providers who are driven toward FFS reimbursement methodologies could take some time with transition to VBP. Additionally, analytics should be completely actionable to drive behavior. This should be directly aligned with existing metrics (ie PCMH, QARR) so providers can leverage existing expertise to achieve goals.

Provider Behavior: Provider resistance to change is a factor that we may encounter, whether due to resource issues, workforce instability or inefficient processes. Sufficient training and support will be necessary to overcome this risk.

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions:

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

Financial Sustainability relies on funds flow (to ensure adequate cash flows to implement DSRIP within each provider's office), workforce (to ensure that adequate training and retraining continue to keep staff engaged and up-to-date with latest DSRIP processes) and practitioner engagement (similarly with staff training, practitioners from all provider types need to remain adequately engaged throughout the DSRIP process). Additionally, internal dependencies exist including governance (ensures appropriate management of provider and PPS financial sustainability and to develop tools to assist providers in need), IT and Performance Reporting (to incorporate all data for accurate reporting of performance).
### IPQR Module 3.5 - Roles and Responsibilities

**Instructions:**

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFO</td>
<td>Wallace Lau</td>
<td>Lead and provide financial function for DSRIP (bookkeeping, procurement, funds flow, etc.). Ensure all departments are compliant with not-for-profit law.</td>
</tr>
<tr>
<td>Treasurer (Board Position)</td>
<td>John McGovern</td>
<td>Present/Execute Finance Workstream goals to the Board.</td>
</tr>
<tr>
<td>Director of Operations - Uptown</td>
<td>Alex Damiron</td>
<td>Ensure Uptown operations functions efficiently and stays within budgeted targets. Develop initiatives as necessary in the event budgets are trending unfavorably.</td>
</tr>
<tr>
<td>Director of Operations - Downtown</td>
<td>Josephine Wu</td>
<td>Ensure Downtown operations functions efficiently and stays within budgeted targets. Develop initiatives as necessary in the event budgets are trending unfavorably.</td>
</tr>
<tr>
<td>Compliance Officer</td>
<td>Tom Hoering</td>
<td>Develop and ensure compliance of Compliance Plan (Social Services Law 363d)</td>
</tr>
<tr>
<td>Fiduciary</td>
<td>NSLIJ (John McGovern)</td>
<td>Development of proper controls that follow non-profit rules as well as DSRIP required processes, AP, AR and other financial functions as required</td>
</tr>
</tbody>
</table>
### IPQR Module 3.6 - Key Stakeholders

**Instructions:**

Please identify the key stakeholders involved, both within and outside the PPS.

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACP Board (Chairman: Dr Ramon Tallaj, MD)</td>
<td>Approval/Rejection of key initiatives associated with DSRIP program.</td>
<td>Ensure appropriate approvals/rejections of initiatives that directly involve execution of DSRIP programs.</td>
</tr>
<tr>
<td>Network Providers</td>
<td>Ensure buy-in of DSRIP program to staff for program execution.</td>
<td>Ensure processes are implemented that follow PPS protocols.</td>
</tr>
<tr>
<td>ACP COOs</td>
<td>Project Management to ensure sustainability of providers</td>
<td>Management of processes and proposals</td>
</tr>
<tr>
<td>CEO (Mario Paredes)</td>
<td>Oversight of overall financial decisions related to the projects and DSRIP in general.</td>
<td>Management of processes and proposals. Ensure adequate quarterly reporting to earn Achievement Values.</td>
</tr>
<tr>
<td>CFO (Wallace Lau)</td>
<td>Oversight of policies regarding financial sustainability</td>
<td>Management of processes and proposals. Ensure adequate quarterly reporting to earn Achievement Values.</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NY DOH and other state/city agencies</td>
<td>Oversight of DSRIP program, designation of Safety Net providers</td>
<td>Ensure Safety Net providers continue to operate to provide services to Medicaid patients. Ensure timely payments to prevent cash flow issues with PPS. Ensure reimbursement policies follow VBP roadmap guidelines that positively impact provider billing practices (ie FFS transition to Level III VBP). Ensure PCMH reimbursement program continues to assist physicians with upkeep of PCMH certifications.</td>
</tr>
<tr>
<td>NCQA/PCMH</td>
<td>Continuous improvement of PCMH (focus on developing evidence-based policy that increases patient satisfaction)</td>
<td>Ensure adequate evolution of policies that focuses on patient satisfaction (increase patient compliance) and preventive measures (early detection of potential chronic diseases).</td>
</tr>
<tr>
<td>MCOs (Affinity, Anthem, Fidelis, Healthfirst, WellCare, etc)</td>
<td>Data source for cost and utilization information</td>
<td>Provide data to track and measure physician performance. Allow for adequate support to providers for VBP.</td>
</tr>
<tr>
<td>CMS</td>
<td>Oversight of DSRIP program</td>
<td>Continued support in DSRIP program, allow for contingencies in the event unintended consequences arise. Align future initiatives with DSRIP goals (ie recent reimbursement policy changes to knee/hip replacement).</td>
</tr>
<tr>
<td>Policymakers</td>
<td>Continued sustainability of Medicaid program</td>
<td>Ensure policies continue to follow VBP and allow for reinvestment into Medicaid program.</td>
</tr>
</tbody>
</table>
IPQR Module 3.7 - IT Expectations

Instructions:
Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

Financial sustainability is very directly related to other key work streams such as funds flow and performance reporting. The strong dependency of funds flow and performance reporting on IT needs to be properly monitored so that providers remain financially sustainable throughout the DSRIP program. This reporting mechanism will help show providers current status and identify areas for improvement (key tools needed to support a provider's path toward high performance), including dashboard reports that may be provided by the DOH. Additionally, IT connectivity amongst providers is important for an effective integrated delivery system (with automatic and real-time data feeds and alerts) which is integral to achieving desired outcomes and measures with patient utilization and management - a major component for achieving financial sustainability for providers.

IPQR Module 3.8 - Progress Reporting

Instructions:
Please describe how you will measure the success of this organizational workstream.

The PPS Finance department will be responsible for developing, monitoring and disseminating reports (with support from IT functions and other work streams) and ensure the financial stability of providers. These progress reports will identify areas of weakness that the Finance department will have to address and support to achieve long term financial sustainability. Progress reporting and mitigation plans will be presented to the Board and Finance Committee so that appropriate corrective action plans can be developed. Additionally, metrics, goals and targets will be established (similar to gap-to-goal targets) to measure performance. Performance metrics include: expense management (appropriate expenses by cost category, especially IP Admissions and Readmissions/ER visits), quality care gaps (ensure patients receive appropriate preventive care), appropriate documentation and establishment of care plans specific to disease categories (ensure patient care has adequate documentation), etc. Ensuring appropriate utilization, as measured by these metrics, will pave the way for a successful VBP environment. Lastly, engagement surveys and measures (1) Completion of Financial Sustainability surveys 2] Success or positive trends regarding overall patient engagement) will provide the PPS the ability to understand financial sustainability of the network providers.

IPQR Module 3.9 - IA Monitoring

Instructions:
Advocate Community Providers, Inc. (PPS ID:25)
### Section 04 – Cultural Competency & Health Literacy

**IPQR Module 4.1 - Prescribed Milestones**

**Instructions:**
Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation. Note some milestones include minimum expected completion dates.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalize cultural competency / health literacy strategy.</td>
<td>In Progress</td>
<td>This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.</td>
<td>08/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Convene Advisory Group/Committee</td>
<td>In Progress</td>
<td>1 Form a Cultural Competency and Health Literacy Advisory Committee of practitioners, advocates and SMEs to provide assistance and recommendations on the implementation of the cultural competency and health literacy strategy.</td>
<td>08/01/2015</td>
<td>08/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>2 Identify Target Areas ('Hotspots')</td>
<td>In Progress</td>
<td>2 Identify and map the &quot;hotspots&quot; in the service area as it pertains to health disparities. The following methodology will be utilized to conduct the assessment: Review of DSRIP Program data on Health Data NY and other publicly available documents, including studies conducted by research institutes and advocacy groups in the field.</td>
<td>08/01/2015</td>
<td>08/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>3 Identify CBOs and Key Partners</td>
<td>In Progress</td>
<td>3 Identify key CBOs and partner organizations that can deploy resources within the PPS to increase cultural competency and health literacy.</td>
<td>09/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>4 Understand Best Practices Regarding Patient Outcomes</td>
<td>In Progress</td>
<td>4 Complete compilation of best practices and methodologies for improving patient’s health outcomes as it pertains to cultural competency and health literacy.</td>
<td>09/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
</tbody>
</table>
### Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV
---|---|---|---|---|---|---|---
**Task 1** Resource Inventory | In Progress | 5 Establish comprehensive inventory of all resources that can be deployed and accessed to increase cultural competency and health literacy across the network. | 09/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 | 0

**Task 6** Educational Campaign | In Progress | 6 Launch fact-finding campaign to gauge the needs of the PPS on issues related to cultural competency and health literacy. Meetings to be held with key physicians and stakeholder organizations coordinated through clinical care teams and the PAC Leadership Council. | 09/01/2015 | 10/31/2015 | 12/31/2015 | DY1 Q3 | 0

**Task 7** Financial Impact Report | In Progress | 7 Complete report on determining the costs associated with developing formal partnership agreements with other entities to help support the work of the PPS. | 10/01/2015 | 10/31/2015 | 12/31/2015 | DY1 Q3 | 0

**Task 8** Complete Final Draft | In Progress | 8 Complete final draft of the comprehensive cultural competency/health literacy strategy, including descriptions of the instruments, processes and procedures for monitoring and evaluating feedback and outcomes across the four major sectors of the PPS. The strategy will also include recommendations for assigning the implementation plan to the ACP Management Team with guidelines as to expected phase-in and completion dates. The assigned management team will be required to prepare quarterly reports on the progress of the plan to the Steering Committee and the Board. | 10/15/2015 | 11/30/2015 | 12/31/2015 | DY1 Q3 | 0

**Task 9** Present/Approve Final Draft | In Progress | 9 Present final draft of the comprehensive cultural competency/health literacy strategy for review and input to the Steering Committee. The Steering Committee submits the final document to the governance body for approval. | 12/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | 0

**Milestone #2** Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material). | In Progress | This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include:
-- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy
-- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches. | 08/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | YES

**Task 1** Convene Advisory Group/Committee | In Progress | 1 Convene Cultural Competency and Health Literacy Advisory Committee to provide input on the training strategy. | 10/01/2015 | 10/31/2015 | 12/31/2015 | DY1 Q3 | 0

**Task 2** Identify Groups Experiencing Health Disparities | In Progress | 2 Conduct Health Literacy Environment Review Survey to assess cultural competency levels, efforts to improve health literacy and training needs throughout the PPS. | 10/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | 0

**Task 3** Review Survey | In Progress | 3 Work with SMEs to review survey results and evaluate training approaches. | 01/01/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | 0

**Task** | In Progress | 4 Draft preliminary training strategy based on data gathered; formulate. | 04/01/2016 | 06/30/2016 | 06/30/2016 | DY2 Q1 | 0

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**NYS Confidentiality – High**
Advocate Community Providers, Inc. (PPS ID:25)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
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<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Draft Training Strategy</td>
<td></td>
<td>desired outcomes and evaluation criteria (i.e. performance metrics) based on assessment of training needs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task 5 Training Strategy</td>
<td>In Progress</td>
<td>5 Submit final draft of training strategy to the Steering Committee for review and input. The Steering Committee submits the final strategy document to the PPS Board of Directors for review and approval.</td>
<td>04/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 6 Implementation</td>
<td>In Progress</td>
<td>6 Commence process of incorporating training into PPS workflow; build guiding coalition of PPS members, select target audiences, identify training vendors, establish training modes and locations, and determine length of training sessions.</td>
<td>04/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
</tbody>
</table>

Prescribed Milestones Current File Uploads

<table>
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<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
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</tbody>
</table>

Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalize cultural competency / health literacy strategy.</td>
<td></td>
</tr>
<tr>
<td>Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).</td>
<td></td>
</tr>
</tbody>
</table>
### IPQR Module 4.2 - PPS Defined Milestones

**Instructions:**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
</table>

No Records Found

### PPS Defined Milestones Current File Uploads

<table>
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<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
</table>

No Records Found

### PPS Defined Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
</table>

No Records Found
IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions:
Please describe the key challenges or risks that you foresee in implementing your cultural competency / health literacy strategy and addressing the specific health disparities you are targeting (based on your CNA), and achieving the milestones described above - including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Cultural competency: There is still debate about what constitutes as cultural competency, and this lack of consensus about the subject matter could potentially impede progress. ACP will mitigate this risk by engaging providers across all sectors in the development of the overall strategy and all related activities within the realm. We will go to our membership for their best ideas, resources and initiatives in order to develop ACP’s strategic vision.

Health literacy: This strategy revolves around overcoming socio-economic barriers to quality healthcare. ACP will mitigate these barriers by deploying Community Health Workers that are from the community they serve. In addition, subject matter experts and key stakeholders from within the communities will assist in the development and evaluation of all materials for cultural appropriateness.

IPQR Module 4.4 - Major Dependencies on Organizational Workstreams

Instructions:
Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

All other workstreams are related to cultural competency. For example, the workforce stream shares the primary goal of assembling a culturally and linguistically competent staff. In addition, the IT platform must facilitate clinical integration across cultures and languages, and report patient demographics including language and ethnicity. Furthermore, practitioner engagement places a high premium on providers that can deliver culturally sensitive care.
### IPQR Module 4.5 - Roles and Responsibilities

**Instructions:**

Please list and elaborate upon the key people/organizations responsible for this workstream and describe what their responsibilities involve.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead, Work stream</td>
<td>Moisés Pérez, Director of Workforce, Community and Government Relations</td>
<td>Implementation Plan / lead development process</td>
</tr>
<tr>
<td>PPS Governance Body</td>
<td>Dr. Ramón Tallaj, MD, Chairman</td>
<td>Approve strategy / provide oversight</td>
</tr>
<tr>
<td>PPS Staff</td>
<td>Leo Pérez Saba, Manager Cultural Competency and Health Literacy</td>
<td>Implementation Plan / Execute project activities</td>
</tr>
<tr>
<td>Subject Matter Experts</td>
<td>Lourdes Rodríguez, Program Officer, New York State Health Foundation. Marianela Núñez, MSW, Independent Consultant. Florence Wong, Deputy Executive Director, 1199SEIU.</td>
<td>Review results of Health Literacy Environment Review Survey in order to assess training needs; provide input into curriculum development, training approaches and evaluation criteria</td>
</tr>
<tr>
<td>Curriculum Development Vendor</td>
<td>City University of New York</td>
<td>Curriculum development, training and evaluation</td>
</tr>
<tr>
<td>Training Vendor</td>
<td>TBD</td>
<td>Conduct training sessions</td>
</tr>
</tbody>
</table>
IPQR Module 4.6 - Key Stakeholders

Instructions:
Please identify the key stakeholders involved, both within and outside the PPS.

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>Dr. Juan Tapia, CEO and Founder, Pediatrics 2000</td>
<td>Participate in Advisory Committee / Provide assistance and recommendations on implementation of strategy and training plan</td>
</tr>
<tr>
<td>Physician</td>
<td>Dr. Adegboyega Adebayo, Independent Practitioner</td>
<td>Participate in Advisory Committee / Provide assistance and recommendations on implementation of strategy and training plan</td>
</tr>
<tr>
<td>Physician</td>
<td>Dr Henry Chen, Independent Practitioner</td>
<td>Participate in Advisory Committee / Provide assistance and recommendations on implementation of strategy and training plan</td>
</tr>
<tr>
<td>Hospital Group</td>
<td>Bill Lynch, Chief Operating Officer, Jamaica Hospital Medical Center</td>
<td>Participate in Advisory Committee / Provide assistance and recommendations on implementation of strategy and training plan</td>
</tr>
<tr>
<td>Hospital Group</td>
<td>Representative NSLIJ/TBD</td>
<td>Participate in Advisory Committee / Provide assistance and recommendations on implementation of strategy and training plan</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject Matter Expert</td>
<td>Anthony Feliciano, Director of the Commission on the Public's Health System</td>
<td>Participate in Advisory Committee / Provide assistance and recommendations on implementation of strategy and training plan</td>
</tr>
<tr>
<td>Subject Matter Expert</td>
<td>Todd Bennett, Field Coordinator, 1199SEIU</td>
<td>Participate in Advisory Committee / Provide assistance and recommendations on implementation of strategy and training plan</td>
</tr>
<tr>
<td>Medicaid Beneficiaries</td>
<td>Ramon Anibal Ramos</td>
<td>Participate in Advisory Committee / Provide assistance and recommendations on implementation of strategy and training plan</td>
</tr>
<tr>
<td>CBO</td>
<td>Malynda Jordan, Director, Narco Freedom Inc</td>
<td>Participate in Advisory Committee / Provide assistance and recommendations on implementation of strategy and training plan</td>
</tr>
</tbody>
</table>
IPQR Module 4.7 - IT Expectations

Instructions:

Please clearly describe how the development of shared IT infrastructure across the PPS will support the development and implementation of your cultural competency / health literacy strategy and the achievement of the milestones described above.

ACP will develop IT capabilities to identify priority groups, evaluate survey results and build online inventory of resources. In addition, IT resources will be used to facilitate communication with healthcare providers, track training dates and report training program outcomes.

IPQR Module 4.8 - Progress Reporting

Instructions:

Please describe how you will measure the success of this organizational workstream.

Success of the cultural competency and health literacy efforts will be measured using performance metrics linked to desired outcomes. Although the outcomes will be specified and developed throughout the implementation process, the measurements of success will fall into several categories, including healthcare navigation system (are patients able to access care?), print communication, oral exchange, use of technology, and policies and protocols. Additionally, patient satisfaction surveys will include questions regarding cultural competency and sensitivity of the providers (i.e. CAHPS survey). The PPS will look to these tools to understand overall cultural competency of practices and its impact on general patient population.

IPQR Module 4.9 - IA Monitoring

Instructions:
Section 05 – IT Systems and Processes

✔ IPQR Module 5.1 - Prescribed Milestones

Instructions:
Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.
Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone #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).</td>
<td>In Progress</td>
<td>Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>NO</td>
</tr>
<tr>
<td>Task 1: Establish Governance Structure</td>
<td>In Progress</td>
<td>1 Establish IT Governance Structure: identify Director of IT, workstream structure and HIT committee.</td>
<td>07/01/2015</td>
<td>08/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 2: Readiness Assessment</td>
<td>In Progress</td>
<td>2 Conduct IT readiness assessment and analyze results - assessment to include readiness of data sharing at provider level, and mapping of the various systems in use throughout the PPS network and their potential interoperability including QE/HIE/RHIOs. Assessment results to be tracked and maintained for each partner within the PPS and gaps addressed to ensure full functionality of an interoperable platform.</td>
<td>08/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 3: Creation of Work Plan</td>
<td>In Progress</td>
<td>3 Data from assessments will drive work plan. Plan expected to include:</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
</tbody>
</table>
## DSRIP Implementation Plan Project

### Advocate Community Providers, Inc. (PPS ID: 25)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
<td><strong>Task</strong> 4 Final Report</td>
<td>In Progress</td>
<td>4 Develop final report, including work plan to close gaps and impact to implementation of an interoperable IT platform, and present to leadership/Board.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 5 Share/Review Results</td>
<td>In Progress</td>
<td>5 Share results of IT readiness assessment and work plan with network partners and discuss implications at Provider IT workgroups and committee meetings.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 6 Workgroup Feedback</td>
<td>In Progress</td>
<td>6 Incorporate workgroup and committee suggestions into final plan regarding development of interoperable IT platform. Incorporate workgroup and committee suggestions into final plan.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 7 Board Approval</td>
<td>In Progress</td>
<td>7 Obtain Board approval.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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### Milestone #2

#### Develop an IT Change Management Strategy.

- **Task** 1 Key Stakeholder Support In Progress 1 Acquire support and buy-in from key stakeholders (Board, committees, PAC).                                                                 | 07/01/2015 | 09/30/2015 | 09/30/2015       | DY1 Q2                          |    |
- **Task** 2 Current State Review In Progress 2 Understand current landscape based on assessment results.                                                                                       | 10/01/2015 | 12/31/2015 | 12/31/2015       | DY1 Q3                          |    |
- **Task** 3 Future State Review In Progress 3 Identify changes required to achieve future target state of delivery system integration.                                                            | 10/01/2015 | 12/31/2015 | 12/31/2015       | DY1 Q3                          |    |
- **Task** 4 Catalogue Results In Progress 4 Catalogue required changes into system-wide/PPS level, individual provider/partner level, or other and prioritize based on PPS goal of delivery system integration. | 10/01/2015 | 12/31/2015 | 12/31/2015       | DY1 Q3                          |    |
- **Task** 5 Change Management Process In Progress 5 Establish process to deploy system changes at various levels (system-wide vs provider level). Process includes: 1) announces planned changes 2) determine business impact 3) determine process impact 4) forum for discussion regarding proposed change 5) Establish support structure and resource expectations and availability (establish roles - PPS responsibility vs partner/other party responsibility) | 01/01/2016 | 03/31/2016 | 03/31/2016       | DY1 Q4                          |    |
<table>
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<tr>
<th><strong>Milestone/Task Name</strong></th>
<th><strong>Status</strong></th>
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<th><strong>DSRIP Reporting Year and Quarter</strong></th>
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<tbody>
<tr>
<td><strong>Task</strong> 6 Planned/Unplanned Changes</td>
<td>In Progress</td>
<td>6 Establish protocols to respond to planned and unplanned changes. Previous steps can apply to both changes based on assessments from previous milestone and any future planned or unplanned changes.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task</strong> 7 Board or Other Approval</td>
<td>In Progress</td>
<td>7 Formalize process (ie formalization of Change Management Policies and Procedures), obtain required approvals, and communicate change request process to internal staff and external partners.</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Milestone #3</strong> Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network</td>
<td>In Progress</td>
<td>Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include:  -- A governance framework with overarching rules of the road for interoperability and clinical data sharing;  -- A training plan to support the successful implementation of new platforms and processes; and  -- Technical standards and implementation guidance for sharing and using a common clinical data set  -- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care management records (completed subcontractor DEAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Task</strong> 1 Establish Governance Structure</td>
<td>In Progress</td>
<td>1 Establish governance structure. Director of IT (John Dionisio) will champion development of roadmap. Acquire support and buy-in from key stakeholders including CEO (Mario Paredes), CMO (Dr Jackson Kuan), Director of Clinical Operations (Lidia Virgil), HIT Committee (Chair: John Dionisio), PAC, and Board.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td><strong>Task</strong> 2 Define Project Needs</td>
<td>In Progress</td>
<td>2 Define needs of the ten projects regarding clinical data needs, connectivity and system requirements, and interoperability functionalities, including EHR interface, workflow development, clinical protocols to establish common clinical processes (which lead to common clinical data sets).</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 3 Compare Results</td>
<td>In Progress</td>
<td>3 Compare needs against IT Assessments results. Leverage existing processes where possible.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>4 Establish key parameters and guiding principles including:</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

Advocate Community Providers, Inc.  (PPS ID:25)

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</table>
| 4 Establish Guiding Principles            |                  | - Respect physician/practitioner's time - minimize any additional steps and maximize automation ('Let Physicians be Physicians').  
- System shall integrate with existing EHRs if certified. Maximize utilization of existing certified EHRs where clinical data can be aggregated and shared so appropriate providers and care management staff has access to relevant clinical history to optimize care and establishment of care plans.  
- Ensure training and support is readily available.  
- Data security is a priority. Provide proper training to key staff, key stakeholders, network providers and ensure agreements (BAAs, subcontractor DEAAs, Participation Agreements, appropriate HIPAA/HIE consent forms) are in place.  
- Functionalities of integrated system must adhere to evidence-based clinical protocols (ie automation of care plans for all diabetics). Any updates to clinical protocols must be incorporated in a timely manner (as part of change management system).  
- Follow PCMH processes where applicable to allow for singular process requirements where possible.                                                                                                                                                                                                                                           |            |          |                  |                               |    |
| Task 5 Target Operating Model Findings    | In Progress      | 5 Leverage findings from Target Operating Model workshops (facilitated by KPMG) - including Context Operating Model (to ensure requirements are traced back to functionality) and Capability Reference Model (ensure processes are comprehensive and consider various use-case scenarios likely to face ACP's operations (while considering 80/20 rule - use cases covers 80% of probable future scenarios). Additionally, utilize Business Requirements Documents and System Requirement Specifications created as a result for TOM workshops to drive workflows and systematic processes during system design of interoperable system.                                                                 | 04/01/2015 | 09/30/2015 | 09/30/2015       | DY1 Q2                       |    |
| Task 6 Engage Back Office Vendor          | In Progress      | 6 ACP is expected to use a key vendor partner to provide back-office functionalities such as cell center, HIE development, centralized care management operations (ACP is still under negotiations with vendor as of this draft and is unable to name vendor). Vendor will plan an integral role in the development of interoperable system as well as workplans and timelines.                                                                                                                                  | 10/01/2015 | 12/31/2015 | 12/31/2015       | DY1 Q3                       |    |
| Task 7 Utilize Partner IT Assessments     | In Progress      | 7 Utilize partner IT assessments to develop interoperable connectivity plan specific to each partner within ACP's network. If EHRs are certified, interface capabilities exist to connect and integrate data (HL7, CCD, CCDA, SIU, etc). Providers with non-certified EHRs or paper records will be strongly encouraged to convert to a certified EHR. As a stop-gap measure, providers in this category will utilize portal access to securely exchange information.                                                                                                                                 | 10/01/2015 | 03/31/2016 | 03/31/2016       | DY1 Q4                       |    |
### Milestone/Task Name

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<tr>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td><strong>Task</strong> 8 RHIO Connectivity In Progress</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>8 RHIO connectivity will be established to finalize interoperability and clinical data sharing.</td>
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<tr>
<td><strong>Task</strong> 9 Board or Other Approvals In Progress</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>9 Obtain necessary approvals to finalize roadmap.</td>
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<tr>
<td>Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td>NO</td>
</tr>
<tr>
<td>PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.</td>
<td></td>
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<tr>
<td><strong>Task</strong> 1 Identify System Needs In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>1 Identify system needs, interfaces, and action plan for existing / new attributed members, ensuring culturally and linguistically appropriate needs are defined and included in plan, to engage members in QEs. Additionally, ensure outreach staff (with appropriate cultural competence and linguistic capabilities) is hired and trained. Language translation services can be used if necessary. Utilize DOH post-opt out attribution roster to determine target population.</td>
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<tr>
<td><strong>Task</strong> 2 Gap Analysis In Progress</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>2 Perform gap analysis of existing communication channels to engage with attributed members, establish strategies based on results of gap analysis. EHR demographic data as well as MCO demographic data can be leveraged and cross-referenced to ensure contact information is accurate. Any existing relationship with member will be key in physically reaching member. Outreach can be performed in various ways including direct telephonic, mailers and utilization of Community Health Worker model for hard to reach members.</td>
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<tr>
<td><strong>Task</strong> 3 Monitor Outreach Effectiveness In Progress</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>3 Monitor reach rates to determine if outreach channels need to be modified or new channels established. Emphasize use of Community Health Worker model where literature suggests high success rates over general telephonic or mailing outreach. Health fairs and presence in community health centers can assist with engaging patients who may not be reachable using traditional methods.</td>
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<tr>
<td><strong>Task</strong> 4 Ensure Continued Engagement In Progress</td>
<td>01/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>4 PPS needs to ensure engaged members continue to be engaged. Various outreach including smart-phone application technologies will be explored to maintain engagement levels.</td>
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<tr>
<td><strong>Task</strong> 5 Metrics In Progress</td>
<td>04/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td>5 Incorporate patient engagement metrics into performance monitoring to understand remaining required Scale and Speed engagements and existing care gaps.</td>
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<td>Milestone/Task Name</td>
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<tr>
<td>Milestone #5</td>
<td>In Progress</td>
<td>Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
</tr>
<tr>
<td>Task 1 Understand DSRIP Requirements</td>
<td>In Progress</td>
<td>1 Understand DSRIP requirements for data security and confidentiality at the PPS level regarding HIPAA, HITECH, telecom, internet and cloud-based securities, mobile/wireless devices (phone, laptop, mobile drives, usb and other mobile media), at-rest and during transmission and transfer encryption of data, physical security of server rooms and employee computers, laptops and other peripherals and employee roles and responsibilities.</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
</tr>
<tr>
<td>Task 2 Creation of Policies and Procedures</td>
<td>In Progress</td>
<td>2 Create policies and procedures to address security and confidentiality issues. Policies and procedures shall include specific sections regarding appropriate use of Mental Health, Substance Abuse and HIV data.</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
</tr>
<tr>
<td>Task 3 Define Access Rights</td>
<td>In Progress</td>
<td>3 Establish roles and access rights to determine who can access patient records. Establish minimum necessary use and disclosure of PHI policies, including 'break the glass' policies. Policies regarding roles and access shall include proper identification and authentication of employee who is accessing records (additionally, HR policies shall include appropriate background checks of employees including review of any appropriate exclusion lists).</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
</tr>
<tr>
<td>Task 4 Data Security and Confidentiality at the Network Provider Level</td>
<td>In Progress</td>
<td>4 Policies and procedures shall also include provider-level data security and confidentiality plan including adequate compliance and HIPAA training for network providers, partners and appropriate staff.</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
</tr>
<tr>
<td>Task 5 Contingency and Emergency Planning</td>
<td>In Progress</td>
<td>5 Contingency and emergency planning policies and procedures will be developed to ensure proper protocols are in place in the event of disasters or emergency events. Policies will include: data backup plans, disaster recovery plan, emergency mode operation plan, testing and revision procedures and applications and data criticality analysis.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
</tr>
<tr>
<td>Task 6 Training Policy and Timeframes</td>
<td>In Progress</td>
<td>6 Appropriate training/education (as well as annual/as needed re-training and re-education) policies and scheduling will be developed to ensure all employees are aware of latest data security and confidentiality policies and to understand regular and anonymous reporting mechanisms (contact information for Compliance Officer and Privacy Officer will be distributed to all employees) in order to appropriately report issues or potential breaches.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
</tr>
<tr>
<td>Task 7 RHIO/SHIN-NY Policy</td>
<td>In Progress</td>
<td>7 Policies regarding RHIO and SHIN-NY connectivity will be developed that incorporates internal policies and procedures as well as RHIO and SHIN-NY policies and procedures.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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</table>
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  
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Prescribed Milestones Current File Uploads

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<th>Milestone Name</th>
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<th>File Name</th>
<th>Description</th>
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Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>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).</td>
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<tr>
<td>Develop an IT Change Management Strategy.</td>
<td></td>
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<tr>
<td>Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network.</td>
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</tr>
<tr>
<td>Develop a specific plan for engaging attributed members in Qualifying Entities</td>
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<tr>
<td>Develop a data security and confidentiality plan.</td>
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</table>
IPQR Module 5.2 - PPS Defined Milestones

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
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PPS Defined Milestones Current File Uploads

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PPS Defined Milestones Narrative Text

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<th>Narrative Text</th>
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<tr>
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</tbody>
</table>
IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions:

Please describe the key challenges or risks that you foresee in creating and implementing your IT governance structure, your plans for data sharing across your network, your approach to data security and confidentiality, and the achievement of the milestones described above, including the potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

IT Adoption: our preliminary current state assessment found a wide variety of IT readiness among participating providers. Some providers may be reluctant to adopt EHRs within tight timeframes to achieve MU 1/2, PCMH Level 3, and be linked into the clinically interoperable system within the tight timeframe. Our IT Transformation Group has discuss possible risk mitigating strategies. 1) For network partners who are still on paper-based records, we have negotiated special pricing package with two of the more frequently used EHRs within our network, some of our hospital partners are also offering EHRs subsidy programs, there is also the option of free EMRs such as Practice Fusion which is 2014 certified, and there is also a short-term option of online care planning through "lite" versions of EHRs. A capital loan for EHR purchase and PCMH 2014 Level 3 certification adjusted towards DSRIP based savings may also be an option. In addition, we plan to create a trained EHR-MU support team to assist the practice to adopt EHRs, from installation, training through MU attestations. For those who are on EHRs, we plan to assemble a trained PCMH 2014 Level 3 support team to assist the practice to achieve certification by DY3. We are also assembling a data analysis team who will be skilled in Salient tool and analytic reporting to support custom programming of performance reports to support education, monitoring, and rapid cycle evaluation among network providers. The State is working out the patient consent policy, procedures, and provision of patient level data which will help finalize the patient engagement plan. With respect to connectivity to the State's Health Home platform or RHIO / SHNY-NY, we are awaiting the State's guidance document. State working out patient consent policy, procedures and provision of patient level data.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions:

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

The IT Committee will not be able to drive the technological infrastructure transformation and development program without working closely with the PPS Finance Committee to review available capital and DSRIP funding sources. We also need to work closely with the PPS Workforce Committee because additional IT staff is also required for adding new technologies, interfaces, reporting and monitoring solutions, and providing assistance and support to our over 4,000 partners within our PPS network. In addition, training of the workforce to use new and expanded systems effectively will also be crucial. The success of the IT Committee's development and transformation work streams have direct impact on the success of many of the other PPS work streams, including, in particular, clinical integration, population health management, performance reporting, and development of an integrate delivery system.
### IPQR Module 5.5 - Roles and Responsibilities

**Instructions:**

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person/organization (if known at this stage)</th>
<th>Key deliverables/responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of IT</td>
<td>John Dionisio</td>
<td>IT Governance, Change Management, IT architecture</td>
</tr>
<tr>
<td>Data infrastructure and Security Lead</td>
<td>Rong Zhao</td>
<td>Data security and confidentiality plan, data exchange plan and other operational requirements, both internal and external to the PPS</td>
</tr>
<tr>
<td>HIE Application Lead</td>
<td>Rong Zhao</td>
<td>Application strategy and data architecture</td>
</tr>
<tr>
<td>HIE Application Support</td>
<td>Back-Office Vendor</td>
<td>Application strategy and data architecture</td>
</tr>
<tr>
<td>IT Operations Proj Manage and PCMH</td>
<td>Pabel Medina</td>
<td>Ensure proper controls and protocols are in place for effective day-to-day operational activities including monitoring</td>
</tr>
</tbody>
</table>
**IPQR Module 5.6 - Key Stakeholders**

Instructions:
Please identify the key stakeholders involved, both within and outside the PPS.

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACP Board (Chairman: Dr Ramon Tallaj, MD)</td>
<td>Approval/Rejection of key initiatives associated with DSRIP program.</td>
<td>Ensure appropriate approvals/rejections of initiatives that directly involve execution of DSRIP programs.</td>
</tr>
<tr>
<td>ACP Directors of Operations (Alexander Damiron, Josephine Wu)</td>
<td>Project Management to ensure sustainability of plan</td>
<td>Management of processes and proposals</td>
</tr>
<tr>
<td>Director of IT (John Dionisio)</td>
<td>Oversight of policies, work groups and deliverables regarding IT</td>
<td>Management of processes and proposals. Ensure adequate quarterly reporting to earn Achievement Values.</td>
</tr>
<tr>
<td>IT Committee Chair (John Dionisio)</td>
<td>Interface between IT Committee and front line end users</td>
<td>Input into system design, testing, and training strategies</td>
</tr>
<tr>
<td>PCMH/EHRs-MU Certification Lead (Pabel Medina)</td>
<td>Support and assist PPS network providers to achieve PCMH-EHRs-MU certification by DY3</td>
<td>PCMH 2014 Level 3 certification of all PPS safety net providers by DY3</td>
</tr>
<tr>
<td>Chief Compliance Officer (Tom Hoering)</td>
<td>Approver</td>
<td>Data security plan</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EHRs vendors</td>
<td>Partner in EHRs and HIE solutions</td>
<td>EHRs and HIE solutions that meets DSRIP requirements for integrated delivery system, connectivity and interoperability</td>
</tr>
<tr>
<td>RHIOs/QEs</td>
<td>Global-level data sharing</td>
<td>DSRIP requirements for integrated delivery system, connectivity and interoperability</td>
</tr>
<tr>
<td>NCQA/PCMH</td>
<td>Continuous improvement of PCMH (focus on developing evidence-based policy that increases patient satisfaction)</td>
<td>Ensure adequate evolution of policies that focuses on patient satisfaction (increase patient compliance) and preventive measures (early detection of potential chronic diseases).</td>
</tr>
<tr>
<td>MCOs</td>
<td>Source of data</td>
<td>Ensure interface compatibility and consistency of data feeds</td>
</tr>
</tbody>
</table>
IPQR Module 5.7 - Progress Reporting

Instructions:

Please describe how you will measure the success of this organizational workstream.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual gap assessment - adoption of IT infrastructure, enablement</td>
<td>of clinical workflow, application of population analytics</td>
</tr>
<tr>
<td>- Annual update of IT strategic plan</td>
<td></td>
</tr>
<tr>
<td>- Annual data security audit findings and mitigation plan</td>
<td></td>
</tr>
<tr>
<td>- Monthly workforce training compliance report</td>
<td></td>
</tr>
<tr>
<td>- Monthly project portfolio 'Earned Value’ report for all IT related</td>
<td>projects within DSRIP project portfolio</td>
</tr>
<tr>
<td>- Weekly shared services performance report that includes specific</td>
<td>performance metrics (connectivity levels, adoption and continued appropriate use of protocols and templates, PCMH roll-out plan (if provider is a PCP), project engagement requirements, medical expense performance [provider type specific, ie loss ratios, expense PMPMs for various categories within appropriate levels], quality care gap rates). Most performance metrics are binary (Yes/No, Achieved/Not Achieved) but others will need comparative data (medical expense performance, quality care gap rates)</td>
</tr>
<tr>
<td>- Weekly performance report on each IT vendor's service level</td>
<td>agreement</td>
</tr>
</tbody>
</table>

IPQR Module 5.8 - IA Monitoring

Instructions:
## Section 06 – Performance Reporting

### IPQR Module 6.1 - Prescribed Milestones

**Instructions:**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.

Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td></td>
<td>Performance reporting and communications strategy, signed off by PPS Board. This should include:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish PPS-wide</td>
<td>In Progress</td>
<td>-- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways;</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>NO</td>
</tr>
<tr>
<td>reporting and</td>
<td></td>
<td>-- Your plans for the creation and use of clinical quality &amp; performance dashboards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>communications.</td>
<td></td>
<td>-- Your approach to Rapid Cycle Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1 ACP Reporting</td>
<td>In Progress</td>
<td>1 Develop for ACP a model of the State's PPS-specific dashboard with all the measures, metrics and milestones for PPS-wide and specific to each of the 10 selected project with target completion dates and reporting unit. Discuss with relevant Project Leadership Team, workgroups, sub-committees, committees to strategize, verify processes, reporting structures, identify gaps, needs, possible solutions, including interim solutions before State's roll out of its resources.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Dashboard Model</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Task</strong></td>
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<td></td>
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</tr>
<tr>
<td>2 Communications</td>
<td>In Progress</td>
<td>2 Establish process for regular two-way communications with each level of reporting participants. Discuss with relevant Project Leadership Team and PPS committees to strategize, verify processes, identify gaps, needs, possible solutions.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Process</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Rapid Cycle</td>
<td>In Progress</td>
<td>3 Establish rapid cycle evaluation process and workflow: identify key individuals and key data values that will inform the designated person (s) in a timely fashion of issue, processes and resources to handle the issue, escalation points, and next steps. Review and obtain feedback with Project Leadership Teams, participant champions, PPS committees, especially the Compliance Committee.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4 Finalize Reporting</td>
<td>In Progress</td>
<td>4 Finalize the layered PPS-wide reporting structure: from individual providers through their associated projects' metrics and the Project Leadership Teams,</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Strategy</td>
<td></td>
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</tr>
</tbody>
</table>

**NYS Confidentiality – High**
### Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter | AV
--- | --- | --- | --- | --- | --- | --- | ---
#### Task 5 Education Plan
5 Establish process and schedule for communicating / educating all participating providers and staff their respective performance metrics and reporting structure, and the relation to PPS-wide performance metrics, reporting structure, and rapid cycle evaluation.
| In Progress | up to the Advocate PPS PMO. Performance information made available by the State through MAPP and Salient will be maximally integrated into this reporting structure. We will also incorporate additional items so as to achieve the type of information needed to manage the network towards value-based payment as our PPS evolves. The final performance reporting strategy (including Rapid Cycle Evaluation process) will be signed off by the PPS Board and incorporated into the provider participation agreement. Chief Medical Officer Dr Jackson Kuan, MD and CFO Wallace Lau will be the responsible parties to ensure that clinical and financial outcomes of patient pathways are trending appropriately.
| 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO

#### Task 6 Reporting Schedule
6 Develop interim regularly scheduled performance reports to supplement the State's roll-out, tailored for each reporting layers, from individual providers through their associated projects, Project Leadership Team, PMO, Clinical Quality Committee, Finance Committee, and PPS executive body.
| In Progress | 01/01/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO

#### Task 7 Board Approval
7 Finalize performance reporting and communication plan signed off by PPS Board.
| In Progress | 01/01/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO

#### Task 8 Establish Baseline Parameters
8 Establish performance baseline parameters to identify high performance incentives and corrective action for low performers.
| In Progress | 01/01/2016 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO

### Milestone #2
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.
| In Progress | Finalized performance reporting training program.
| 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | NO

#### Task 1 Develop Analytics Training and Support Group
1 The Analytics Training and Support Group to train PCMH / EHR-MU support team staff on integrating new reporting processes and clinical metric monitoring workflow. There will be an initial one-time training with subsequent periodic refresher training for the trainers. The PCMH / EHR-MU support team staff will be the front-line hands-on educators for on-going assistance and support to participating providers in correct and accurate data input for data collection and reporting and reviewing the reports for timely actionable items.
| In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | NO

#### Task 2 Implementation and Training
2 In collaboration with the Clinical Quality Committee, develop provider and staff training on clinical protocol implementation, performance reporting, rapid cycle evaluation, and communications, leveraging on existing provider.
| In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 | NO

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NYS Confidentiality – High
**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**

**Advocate Community Providers, Inc. (PPS ID:25)**

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task</strong> 3 Training Schedule</td>
<td>In Progress</td>
<td>Organization group meetings. Monthly group meetings began in DY0 and will continue throughout the DSRIP term. Training covers provider and staff roles and responsibilities. Training will include the full range of providers in addition to physicians and their staff; hospital triage / ED staff, home health providers, long term care, behavior health providers, community-based service providers, etc. 3 Schedule and roll out training to all network providers, leveraging on their respective existing meeting of peer groups and hubs for more efficient training schedules and venues. These will include physician offices, as well as hospital triage / ED staff, home health, long term care, behavioral health, community-based services, etc. ACP will start with monthly meetings in DY1 and then transition to quarterly meetings when appropriate.</td>
<td>10/01/2015</td>
<td>10/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 4 Metrics Reporting Training Effectiveness</td>
<td>In Progress</td>
<td>Establish feedback loop to gauge training effectiveness. Providers will be periodically surveyed to check understanding of new policies and procedures established to improve clinical quality. Providers will be provided with monthly/quarterly performance reporting, but as important, follow up items at actionable levels (often at the member level). As with milestones listed under Financial Sustainability, adequate support such as a provider engagement team and formal/informal education and training, will be available to ensure providers meet the requirements of DSRIP. Additionally, continual review of performance reporting will highlight providers who require additional training (ex. low care gap completions rates, low patient engagement rates).</td>
<td>10/31/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 5 Identifying Performance Champions</td>
<td>In Progress</td>
<td>In collaboration with leadership staff (Officers and Directors), the training team to identify primary contact at each site and encourage to become performance champions to help cultivate performance reporting culture and ongoing fine tuning of performance reporting, communication plan, rapid cycle evaluation process.</td>
<td>10/31/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
</tbody>
</table>

### Prescribed Milestones Current File Uploads

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish reporting structure for PPS-wide performance reporting and communication.</td>
<td></td>
</tr>
<tr>
<td>Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.</td>
<td></td>
</tr>
</tbody>
</table>
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc. (PPS ID:25)

✅ IPQR Module 6.2 - PPS Defined Milestones

Instructions:
Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

PPS Defined Milestones Current File Uploads

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
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<td></td>
</tr>
</tbody>
</table>

PPS Defined Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
<td></td>
</tr>
</tbody>
</table>
IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions:

Please describe the key challenges or risks that you foresee in implementing performance reporting structures and processes and effective performance management within your network, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Provider and Staff Culture: providers and staff may have been accustomed to a certain culture and now may have to adjust to new ways of documentation. We plan to mitigate this risk thorough dedicated teams for specific communication, education, hands-on training, on-going support, and engagement of all PPS providers and staff on adopted protocols, procedures and metrics. In addition, the IT analytics group and dashboard group will work closely with the user groups, practitioner champions, performance management champions, project leadership teams to design user-friendly, concise, and meaningful and actionable tools and reports to improve accurate reporting, timely and easy access and meaningful interpretation of reports for immediate actionable items, rapid cycle evaluation, including self-evaluation, and feedback to reinforce and cultivate a positive performance reporting experience and culture going forward. Certainly, we will depend on IT systems and processes to address all technical issues properly such as data integration and normalization from different source, dashboard views and security assignments for different users, etc.

IPQR Module 6.4 - Major Dependencies on Organizational Workstreams

Instructions:

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

Departments with major dependencies include Workforce (with IT and Clinical Integration being a key dependency) and Financial Sustainability. IT and Clinical integration allows for the PPS to understand performance at the clinic level in more real time than using claims or other process flows with inherent time lags. Similarly, the PPS can also send data to the providers efficiently that provides feedback on current initiatives. Integration at all levels will allow providers to review performance and develop steps to improve. Additionally, financial sustainability plays a major role in the prioritization of initiatives in a physician office. The provider has to be financially sustainable in order to be effective in deployment of initiatives based on the information from performance reporting.
### IPQR Module 6.5 - Roles and Responsibilities

Instructions:

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of IT</td>
<td>John Dionisio</td>
<td>Develop ACP performance reporting module with underlying layered reporting structure with all measures, metrics, milestones for required reporting, rapid cycle evaluation, manage network evolution to value-based payment.</td>
</tr>
<tr>
<td>10 Clinical Quality Committees</td>
<td>TBD</td>
<td>Criteria, input, feedback as to data elements, decision-making algorithms, data values, technical specifications, user interface specifications. Oversight and review of reports with measurements of performance, provide feedback to providers.</td>
</tr>
<tr>
<td>IT Support Team (including PCMH)</td>
<td>Pabel Medina</td>
<td>Communication, education and continuing education, hand-on assistance, on-going support, cultivation</td>
</tr>
<tr>
<td>IT Committee (Chair: John Dionisio)</td>
<td>IT Committee Members</td>
<td>Establish guidelines for IT platform development to meet reporting metrics in a usable format.</td>
</tr>
<tr>
<td>Provider Engagement Team</td>
<td>TBD</td>
<td>Educate and support ACP participating providers on project metrics and reporting</td>
</tr>
<tr>
<td>Director of Clinical Programs</td>
<td>Lidia Virgil</td>
<td>Together with IT Director establish parameters for reporting, metrics and deliverables. Ensure All ACP providers are engaged and trained on all aspects of project implementation.</td>
</tr>
</tbody>
</table>
**IPQR Module 6.6 - Key Stakeholders**

Instructions:

Please identify the key stakeholders involved, both within and outside the PPS.

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IT Vendors of EHRs and HIEs (various Points of Contact)</td>
<td>Provide required technical capabilities</td>
<td>Access to accurate and timely data required</td>
</tr>
<tr>
<td>Back Office Vendor</td>
<td>Provide required technical capabilities and reporting best practices</td>
<td>Reporting templates, Data and Analytics functionalities</td>
</tr>
<tr>
<td>ACP Directors of Operations (Alexander Damiron, Josephine Wu)</td>
<td>Project Management to ensure sustainability of providers</td>
<td>Management of processes and proposals</td>
</tr>
<tr>
<td>Director of IT (John Dionisio)</td>
<td>Oversight of policies, work groups and deliverables regarding IT</td>
<td>Management of processes and proposals. Ensure adequate quarterly reporting to earn Achievement Values.</td>
</tr>
<tr>
<td>PCMH/EHRs-MU Certification Lead (Pabel Medina)</td>
<td>Support and assist PPS network providers to achieve PCMH-EHRs-MU certification by DY3</td>
<td>PCMH 2014 Level 3 certification of all PPS safety net providers by DY3</td>
</tr>
<tr>
<td>PAC</td>
<td>Advise and assist by providing feedback from PPS network and community at large</td>
<td>Advise on reporting metrics, clarity and frequency of distribution</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data consumers</td>
<td>Use data to gauge performance for their own network, or other network providers, individually or collectively</td>
<td>Comparative score cards</td>
</tr>
<tr>
<td>MCOs (various Points of Contact)</td>
<td>Provide supplemental data</td>
<td>Supplemental data for performance reporting, managing network and its evolution to value-based payment</td>
</tr>
<tr>
<td>RHIO/SHIN-NY (Healthix, Bronx RHIO, Inter-Boro)</td>
<td>Global-level data sharing</td>
<td>DSRIP requirements for integrated delivery system, connectivity and interoperability and common data sets</td>
</tr>
</tbody>
</table>
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc. (PPS ID:25)

IPQR Module 6.7 - IT Expectations

Instructions:

Please clearly describe how the development of shared IT infrastructure across the PPS will support your approach to performance reporting.

Having IT infrastructure across the PPS will facilitate the performance reporting process, in a more efficient, comprehensible manner with less effort and time compared to manual reporting. All information will be gathered centrally in a secure HIPAA compliant data warehouse, normalized, integrated, longitudinal, from which all metrics may be gathered, organized, analyzed, presented. Data provided by different sources, such as from State, MCOs, EHRs, hospitals, etc. will be reconciled and clearly identified so that all analyses, projections, and presentations are accurate.

IPQR Module 6.8 - Progress Reporting

Instructions:

Please describe how you will measure the success of this organizational workstream.

ACP will create a performance reporting platform for the PPS which will integrate measurable activities performed by each partner, physician, non-physician, organizational, community based, etc. to allow for reporting and monitoring of all services provided to attributed patients and the overall community population. The platform is to be accurate, timely, easily accessible, meaningful and actionable for all levels of participants involved, so that all are informed / educated, motivated to contribute to constructive decision-making and actions to drive improvements, deploy resources, and work towards achieving DSRIP program goals. Data gathered will be used to monitor performance, but also to enhance services provided to the communities ACP serves. Specifically, data that measures the requirements of engagement and gap-to-goal care gap hit rates, as well as performance data (admissions, re-admissions within 30 days and ED cost and utilization rates [admits/1000, days/1000], acuity scores, preventive medicine such as immunizations and screenings, etc). ACP will also measure care plan compliance which will include both provider and member compliance (compliance with approved care plans are key to the success of ACP) and achieving target states (ie controlled blood pressure and appropriate A1C levels). Additionally, reports on effectiveness of training programs that focus impacting utilization metrics will be created to identify provider understanding of reports, actionable steps and overall engagement with DSRIP requirements. Metrics will include: Participation - providers are open to training and subsequent retraining if necessary, Follow-thru - measuring follow thru of provider with set goals (ie close specific care gaps in agreed-upon time frame) and positive trending of engagement membership.

IPQR Module 6.9 - IA Monitoring

Instructions:

NYS Confidentiality – High
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc.  (PPS ID:25)
Section 07 – Practitioner Engagement

**IPQR Module 7.1 - Prescribed Milestones**

Instructions:

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone #1 Develop Practitioners communication and engagement plan.</td>
<td>In Progress</td>
<td>Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups -- The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td>NO</td>
</tr>
<tr>
<td>Task 1 Create Practitioner Engagement Team</td>
<td>Completed</td>
<td>1 Create practitioner engagement team and practitioner engagement plan led Lidia Virgil, Director of Programs</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 2 Recruit Practitioner Champions</td>
<td>In Progress</td>
<td>2 Recruit Practitioner champions and influencers from among the key professional practitioner groups such as physicians, nurses, behavioral health and substance abuse practitioners, community health workers, navigators and others throughout the care continuum within the ACP service area. Organize these individuals as a representative body that will represent the views of practitioners to the ACP Board. This group of selected practitioner champions and influencers will participate on the Clinical Quality Committee and will serve as the spokespersons for their respective professional peer groups. Clinical Quality Committee will be chaired by Dr Jackson Kuan, MD with support from workstream directors (Lidia Virgil, John Dionisio).</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 3 Develop a Communication Campaign Strategy</td>
<td>Completed</td>
<td>3 Develop a communication campaign leveraging existing professional groups to gather and stimulate practitioners for participation in physician engagement meetings.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 4 Develop Physician Engagement Teams</td>
<td>Completed</td>
<td>4 Develop physician engagement teams which will provide on site support and guidance to practitioners. These teams will periodically visit the practitioners and maintain active contact with them to encourage compliance and serve to liaise between the individual practitioner and the PPS.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Completed</td>
<td>5 Develop a practitioner engagement meeting plan with established PPS wide</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**

**Advocate Community Providers, Inc. (PPS ID:25)**

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Develop Physician Engagement Plan</td>
<td></td>
<td>Practitioner meetings to provide updates on implementation and performance and provide the practitioner a platform for actively providing feedback and discussing any issues.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task 6 Develop DSRIP Protocol Manual</td>
<td>Completed</td>
<td>6 Develop user friendly materials for distribution to physicians on DSRIP processes and procedures including reporting metrics, Evidence based protocols, procedure manuals for support.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 7 Develop Reporting Metrics and Benchmarks</td>
<td>In Progress</td>
<td>7 Develop reporting metrics and benchmarks to be used to monitor compliance with DSRIP measures and provide training to practitioners on each measure. Metrics include patient engagement, care gap close rates, care plan compliance, etc.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
</tbody>
</table>

**Milestone #2**  
Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 1 Develop Education Campaign</td>
<td>Completed</td>
<td>1 Develop educational campaign and training venue for practitioner that provides information on Key Goals and Objective of the DSRIP program by Lidia Virgil, Director of Programs.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 2 Develop Evidence-Based Protocols</td>
<td>Completed</td>
<td>2 Develop and disseminate evidence-based protocols for project implementation and performance.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 3 Develop Procedure Manual and How-to's</td>
<td>Completed</td>
<td>3 Develop procedure manuals and how-to workflow tools for documenting procedures.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 4 Develop Performance Reporting</td>
<td>In Progress</td>
<td>4 Develop downstream reporting to present to individual practitioners regarding individual performance and corrective action plans for quality improvement.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 5 Hold Practitioner Engagement Meetings</td>
<td>Completed</td>
<td>5 Hold PPS wide practitioner engagement meetings to educate on DSRIP goals and requirements.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 6 Develop ACP Website Repository</td>
<td>In Progress</td>
<td>6 Develop ACP website and include all DSRIP support information, ACP procedures, processes, protocols and reporting structure.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
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**Prescribed Milestones Current File Uploads**

<table>
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<tr>
<th>Milestone Name</th>
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<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
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<tbody>
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*New York State Confidentiality – High*
### Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop Practitioners communication and engagement plan.</td>
<td></td>
</tr>
<tr>
<td>Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.</td>
<td></td>
</tr>
</tbody>
</table>
### IPQR Module 7.2 - PPS Defined Milestones

**Instructions:**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
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<tbody>
<tr>
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### PPS Defined Milestones Current File Uploads

<table>
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<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
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</table>

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### PPS Defined Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
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<tbody>
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</tr>
</tbody>
</table>

No Records Found
IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions:
Please describe the current level of engagement of your physician community in the DSRIP program and describe the key challenges or risks that you foresee in implementing your plans for physician engagement and achieving the milestones described above. Describe any potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Practitioner engagement is the initial and ongoing initiative with active and committed practitioners. A substantial portion of the ACP practitioner community currently has a significant interest in the DSRIP program since the program affects their clients, the Medicaid recipients.

Lack of Practitioner Champions and Influencers: The first major risk is that we don’t find a sufficient number of practitioners who are willing and able to take time away from their day job to become significantly involved with ACP in this critical stewardship role. To mitigate this we look to attract those practitioners who are currently leaders in the clinical community and who have shown a strong interest in DSRIP. We also intend to find back-up leaders who are willing and able to step in should the first set of champions and influencers have to step out for whatever reasons.

Physician Behavior Change: Practitioners are in the business of healthcare and therefore the required core behavior changes vital to DSRIP transformation are likely to affect their practice styles and their practice financial situations. This will make it difficult for practitioner champions and influencers to get the average practitioner's buy-in. To mitigate this risk we will establish a value based payment program that rewards practitioners for changing their behavior. Community practitioners are likely to show a resistance to "cookbook medicine" including the adoption and adherence to EBM, clinical protocols and paths. To mitigate this practitioner leaders must be willing and able to model the behavior change required and educate their peers on the necessity to change in order to survive in the future health care system. The development of financial incentives for short run behavior modification and value-based payment in the long run behavior change is a key component of practitioner engagement.

Administrative Support: A majority of the activities surround provider engagement are at the grassroots level. Engagement teams must be very efficient, properly trained, develop lasting relationships and have the ability to cover large territories (ie borough-wide) to ensure provider engagement, training and re-training are adequate. This group will be the main point of contact with the PPS network.

IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

Instructions:
Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

All of the work streams are interrelated. They all depend on an effective and efficient governance structure and process. Our plans for practitioner engagement depend on an HIT infrastructure that allows for reliable communication across the care continuum. We look to make sure that every PCP has an EMR and proficiently uses it. We intend to have our champions practitioners evangelize clinical integration and the use of EBM among independent practitioners. The dual role and responsibilities of practitioner champions extends beyond advocating on behalf of the ACP DSRIP program to practitioners to advocating on behalf of the practitioner communities they represent and communicating information back to the ACP governance. Clinical quality committees and medical directors will have a major impact on the practitioner engagement. The Clinical Quality Committees and the Medical Director will have direct oversight and monitor metrics providing invaluable feedback to each provider, encouraging them to achieve higher performance and working to ensure the highest quality of care is given to each patient the PPS serves. It shall provide the
infrastructure to achieve meaningful reporting of performance and continued efficient HIE. Workforce dependencies are a primary source. Practitioners will need much support and a well trained staff in order to provide the best and most efficient, cost effective care, which in turn shall produce success in all DSRIP goals.
## IPQR Module 7.5 - Roles and Responsibilities

**Instructions:**

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Clinical Programs</td>
<td>Lidia Virgil</td>
<td>Manage the development and implementation of the practitioner engagement communication strategy and report progress to the ACP Board</td>
</tr>
<tr>
<td>Physician Champions</td>
<td>Dr Cheng Gonjon, MD, Dr Jose Goris, MD, Dr Juan Tapia, MD, Dr Henry Chen, MD, and others</td>
<td>Motivate physicians in ACP to make necessary behavior changes required by DSRIP, serve on the Clinical Quality Committee; responsible for ACP clinical care project initiatives</td>
</tr>
<tr>
<td>Practitioner Engagement Manager</td>
<td>Doris Canela</td>
<td>Provide outreach and support to practitioners in the implementation of DSRIP projects. Be a consistent point of contact for practitioners.</td>
</tr>
<tr>
<td>Behavioral Health and Substance Abuse Practitioners</td>
<td>Dr Fernando Taveras, MD, Dr Rodney Campos, MD</td>
<td>Motivate behavioral health and substance abuse practitioners in ACP to make necessary behavior changes required by DSRIP, serve on the Clinical Quality Committee; responsible for ACP clinical care project initiatives</td>
</tr>
<tr>
<td>Other Key Service Type Practitioner Champions</td>
<td>Members of PAC leadership council</td>
<td>Motivate other key practitioner types in ACP to make necessary behavior changes required by DSRIP, serve on the Clinical Quality Committee; responsible for ACP clinical care project initiatives</td>
</tr>
<tr>
<td>Patient representative</td>
<td>Ramon Anibal Ramos</td>
<td>Represent the interest of Medicaid recipients and uninsured to practitioner champions with respect to patient centered care.</td>
</tr>
<tr>
<td>New York City Department of Health &amp; Mental Hygiene</td>
<td>Rosemary Martinez</td>
<td>Ensure development disease population policies are current. Provide support to PPS specific to initiatives and engagement activities to developmental disease populations.</td>
</tr>
<tr>
<td>Life Adjustment Center, Inc</td>
<td>Yuri Feynberg, PHD</td>
<td>Provide support to PPS specific to initiatives and engagement activities to developmental disease populations.</td>
</tr>
<tr>
<td>Intellectual and Developmental Disabilities Services</td>
<td>TBD</td>
<td>Provide support to PPS specific to initiatives and engagement activities to developmentally disabled populations.</td>
</tr>
</tbody>
</table>

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**IPQR Module 7.6 - Key Stakeholders**

Instructions:

Please identify the key stakeholders involved, both within and outside the PPS.

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practitioners throughout the network</td>
<td>Target engagement activities</td>
<td>Attend training sessions, specific patient engagement activities, report to relevant Practitioner Champions</td>
</tr>
<tr>
<td>Lidia Virgil, Director of Clinical Programs</td>
<td>Oversight of all training strategies, including practitioner education / training.</td>
<td>Create practitioner engagement, education / training plan</td>
</tr>
<tr>
<td>Clinical Quality Committee</td>
<td>ACP Board committee</td>
<td>Review and advise on practitioner engagement plan and changes to the plan</td>
</tr>
<tr>
<td>Corinthian/Balance IPA Lead (Dr Ramon Tallaj, MD)</td>
<td>Engage and encourage physicians to participate in DSRIP</td>
<td>Liaise with practitioners, assist in planning meetings and engaging practitioners, distribute communications and updates, leverage experience in at risk contracting and value based payments</td>
</tr>
<tr>
<td>ECAP IPA Lead (Dr Henry Chen, MD)</td>
<td>Engage and encourage physicians to participate in DSRIP</td>
<td>Liaise with practitioners, assist in planning meetings and engaging practitioners, distribute communications and updates, leverage experience in at risk contracting and value based payments</td>
</tr>
<tr>
<td>Excelsior IPA Lead (Dr Emilio Villegas, MD)</td>
<td>Engage and encourage physicians to participate in DSRIP</td>
<td>Liaise with practitioners, assist in planning meetings and engaging practitioners, distribute communications and updates, leverage experience in at risk contracting and value based payments</td>
</tr>
<tr>
<td>Dr. Angelo Canedo, Medisys Health System</td>
<td>Engage and encourage Medisys physicians to participate in DSRIP</td>
<td>Liaise with practitioners, assist in planning meetings and engaging practitioners, distribute communications and updates, leverage experience in at risk contracting and value based payments</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOH (PCMH)</td>
<td>Provide incentive payments for PCMH status</td>
<td>Ensure PCMH incentives continue to be a part of the program. Physicians rely on these additional incentives to maintain PCMH status.</td>
</tr>
<tr>
<td>ECW, MD Land</td>
<td>EMR Vendors</td>
<td>Provide training and efficient processes within EMR to create smooth DSRIP compliant workstreams to assist providers in care</td>
</tr>
</tbody>
</table>
IPQR Module 7.7 - IT Expectations

Instructions:

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

Within the evolving New York health care landscape there is an increasing demand for coordination, new organizational structures, greater transparency, greater patient-centered care and value-based payment models. Building strong practitioner engagement and alignment to DSRIP goals and objectives is pivotal to achieving success. Strong practitioner engagement and alignment to the mission, vision and values of ACP is needed to obtain voluntary behavior change. The goal is to meaningfully engage with practitioners in order for them to collaborate and deliver exceptional care and outcomes to the Medicaid and uninsured population. Communication across the continuum of care is fundamental to meeting ACP Goals and Objectives. Stated otherwise, without a newly designed and implemented HIT infrastructure whereby practitioners can share clinical information in an integrated fashion nothing much will change. Therefore, the development of an HIT infrastructure that connects all practitioners large and small in an easy to use platform is a critical necessity for success. We look to create a HIT infrastructure through the use of established vendors. We look to involve practitioner champions in review of the design of the HIT system. Over time we look to make improvements that will heighten the ability of individual practitioners to share clinical information and become part of a clinically integrated whole. An HIT infrastructure that will meet the needs of DSRIP healthcare transformation will also be critical for the success of practitioner engagement.

IPQR Module 7.8 - Progress Reporting

Instructions:

Please describe how you will measure the success of this organizational workstream.

Being able to attract a sufficient number of dedicated practitioner champions and influencers for our practitioner education and training programs is a first indicator of our ability to be successful in rolling out this work stream. The number of practitioners who enroll and turn out for the engagement programs is a further indicator of success. We look to deliver education and training by using various venues such as face to face, Webinars, conference calls, learning collaboratives and web-based/online training. We look to establish target metrics for success as well as develop various assessment methods and tools such as testing (pre and post), interviews, discussion forums, town halls as well as questionnaires. These metrics include: attendance (report on attendance logs), patient engagement rates (report on volume of patients with project-specific engagement requirements), care gap hit rates, performance data (admissions, re-admissions and ED cost and utilization rates [admits/1000, days/1000, acuity score]), also gauged for performance will be achievement of disease specific target goals and disease progression or detention rates. ACP will also measure care plan compliance, an indicator that providers are engaged and following established care plans (while considering the potential for member non-compliance).
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc. (PPS ID:25)

Instructions:

NYS Confidentiality – High
### Section 08 – Population Health Management

#### IPQR Module 8.1 - Prescribed Milestones

**Instructions:**

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement.

Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td>In Progress</td>
<td>Develop population health management roadmap. Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td>NO</td>
</tr>
<tr>
<td>Task 1 Identify Hotspots</td>
<td>In Progress</td>
<td>1 Based on the CNA results, identify population hotspots, both in the PPS area and in specific geographic areas, to target those with greatest needs within each of the chosen projects. Solicit participating providers' feedback before finalization.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 2 Distribute Protocols</td>
<td>In Progress</td>
<td>2 Distribute protocols/ care guidelines for providers on engaging and treating target population. Establish metrics for each clinical area to monitor progress in managing population health.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 3 Create Reporting Dashboard</td>
<td>In Progress</td>
<td>3 Create a dashboard that can be easily accessed by all participating providers to monitor population health outreach and patient engagement and compliance.</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 4 Create Workgroup</td>
<td>In Progress</td>
<td>4 Create Clinical Operations/IT Workgroup to establish population health criteria with metrics to incorporate within integrated delivery system design.</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 5 Data Inventory</td>
<td>In Progress</td>
<td>5 Inventory available data sets with individual demographic, health, and community status information , to supplement our use of the data available through available state tools such as MAPP tool, etc.</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 6 Database Development</td>
<td>In Progress</td>
<td>6 Develop a relational database for individual care management. Perform data analyses to identify target population through algorithms and registries; identify priority practice groups to have access to registries</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 7 Complete workforce assessment for priority practice groups' care</td>
<td>In Progress</td>
<td>7 Complete workforce assessment for priority practice groups' care</td>
<td>04/01/2015</td>
<td>03/30/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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## New York State Department Of Health
## Delivery System Reform Incentive Payment Project
## DSRIP Implementation Plan Project

### Advocate Community Providers, Inc.  (PPS ID:25)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
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<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Workforce Assessment</td>
<td></td>
<td>Management capabilities, including staff skills and resources required to manage priority at risk populations in each geographic area. Develop workforce training / re-training / support staff assignment to mitigate workforce gaps.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task 8 PCMH</td>
<td>In Progress</td>
<td>Establish PCMH / EHR-MU Certification Team and vendor support to identify key gaps and develop plan to achieve Level 3 certification by DY3.</td>
<td>10/01/2015</td>
<td>03/30/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task 9 Support Staff Deployment</td>
<td>In Progress</td>
<td>Deploy staff support at provider level to train providers to use and apply information learned from registries; how to implement established care guidelines; develop disease pathways; inform on metrics for monitoring progress in managing population health; implement plan to achieve PCMH Level 3 certification by DY3.</td>
<td>10/01/2015</td>
<td>03/30/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task 10 Promotional Education Materials</td>
<td>In Progress</td>
<td>Create promotional educational materials and distribution plan for population wide health campaigns</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 11 CBO Engagement</td>
<td>In Progress</td>
<td>Work with CBOs and other PPS's in reaching target populations, disseminating materials in a culturally sensitive manner in the promotion of population health and specifically those projects chosen by ACP PPS.</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task 12 Finalize CBO Agreements</td>
<td>In Progress</td>
<td>Finalize Agreements with CBOs for the provision of services related to population health in specific projects such as tobacco cessation, sex education, cancer prevention, etc.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task 13 Finalize Roadmap</td>
<td>In Progress</td>
<td>Clinical Quality Committee to finalize population health management roadmap</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Milestone #2 Finalize PPS-wide bed reduction plan.</td>
<td>In Progress</td>
<td>PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task 1 Establish Service Utilization Monitoring Team</td>
<td>In Progress</td>
<td>Establish Service Utilization Monitoring Team (SUMT) with partner hospitals and behavioral health units / facilities. This team will report to the PMO and Clinical Quality Committee and will be responsible for monitoring and reporting on reductions in avoidable hospital use and modeling the impact of all DSRIP projects on inpatient activities. Team will collect and produce utilization reports based on bed type (BH, Med/Surg, OB/Maternity) and utilization in the ED to ensure appropriate metrics are developed for each bed type and department.</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 2 Data Analysis</td>
<td>In Progress</td>
<td>SUMT to analyze and model the impact of all DSRIP projects on avoidable hospital use and utilization of hospital services (inpatient and outpatient) and demand for community-based services. Model can be updated regularly (monthly or quarterly)</td>
<td>10/01/2015</td>
<td>03/30/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
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**NYS Confidentiality – High**
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Advocate Community Providers, Inc. (PPS ID:25)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 3 Data Forecasting</td>
<td>In Progress</td>
<td>3 Based on the modeling and in consultation with provider network, establish a high level forecast of: - Reduced avoidable hospital use over time - Changes in inpatient capacity (including BH, Med/Surge, OB/Maternity and others) - Resulting changes in community / outpatient / ED capacity (non-psych/MH/SUD ED and psych/MH/SUD-ED)</td>
<td>01/01/2016</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 4 Draft Capacity Plan</td>
<td>In Progress</td>
<td>4 SUMT to lead consultation on first draft capacity change plans</td>
<td>04/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 5 Publish Capacity Plan</td>
<td>In Progress</td>
<td>5 Finalize and publish final capacity change / bed reduction plan and schedule updates of capacity changes across the network</td>
<td>10/01/2016</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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Prescribed Milestones Current File Uploads
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Prescribed Milestones Narrative Text

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<th>Milestone Name</th>
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<tr>
<td>Develop population health management roadmap.</td>
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<tr>
<td>Finalize PPS-wide bed reduction plan.</td>
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</table>
### IPQR Module 8.2 - PPS Defined Milestones

**Instructions:**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

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<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
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### PPS Defined Milestones Current File Uploads

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### PPS Defined Milestones Narrative Text

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<th>Milestone Name</th>
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<td>No Records Found</td>
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</tbody>
</table>
IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions:

Please describe the key challenges or risks that you foresee in implementing these cross-cutting organizational strategies, including potential impacts on specific projects and, crucially, any risks that will undermine your ability to achieve outcome measure targets.

Provider and Staff Culture: Changing the culture of how services are delivered represents a true challenge in the area of population health. At present, the healthcare system is set up in a way that care is delivered on a one on one basis and is delivered in the face of specific conditions, to address those specific conditions. In the population health projects, the PPS will need to address conditions that a patient and/or member of the target population may not have yet. The culture of all of the practices must be changed to a more predictive and proactive method. This will be difficult as it represents additional expenses at little or no reimbursement since at present, there is little to no reimbursement on the part of payers for preventive services. The PPS aims to mitigate this risk by negotiating with payers, MCOs to provide reimbursement for educational visits, and other preventive care services. The PPS will also mitigate this risk through the training and retraining of its providers in the provision of preventive care services. Another way to mitigate this risk is through population wide campaigns through several methods, achievable with the help of Community partners.

Patient Engagement: Another risk is in effectively reaching out to and engaging the at risk populations. ACP plans to mitigate this risk with the use of Community Health Workers/Health Advocates who have direct connections with the community and share cultures and language with the patients.

Population Health Analytics: Another risk is that population health data analyses are time consuming and expensive and it takes a long time for organizations to develop new services or interventions. To mitigate this risk, we plan to start with available high level data at hand from our CNA, refine them and apply them at actionable levels first and then supplement them with the more detailed data analyses.

Continue population health management approach: To facilitate continued education and cultivation of the population health management approach, we will improve on our communications and workforce training strategies to ensure meaningful education on population health management.

IPQR Module 8.4 - Major Dependencies on Organizational Workstreams

Instructions:

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

Successful implementation of multiple workstreams will contribute significantly to the development of effective population health management across ACP PPS.

1. Effective and rapid communication and data sharing will be used to ascertain defined target and outreach methodology for implementation of population health initiatives Thus, a robust and functional set of data gathering and monitoring tools surveys, CNA, registries shall be implemented with the IT platform functionality.

2. Population Health will also be highly dependent on workforce as it will require staff re-training as well as new staff deployment including
community health workers/health advocates, etc.

3. Finance has an integral role in population health management since all campaigns and new systems and processes will require a financial commitment from the PPS to cover high costs of same.

4. Governance in all of its forms will play a key role since agreements with CBOs, community leaders, other PPS’ will have to be in place for shared information and outreach. The PMO will have direct intervention in since it will distribute and implement protocols and processes for patient engagement and intervention.

5. Another major dependency is the Provider Engagement team, who will have to provide the providers with information, training materials and achieve provider buy in and support. Training or re-training of care managers, care coordinators, and other care team support staff would also be a key dependency for our network providers. In addition, an integrated delivery system where information technology are leveraged for clinical care would help to round out the tool set for the population health management care team.

6. Cultural competency is also important in educating and engaging patients in taking appropriate action and changing health behaviors in the PPS’ population health projects of tobacco cessation and prevention of chronic diseases.
## IPQR Module 8.5 - Roles and Responsibilities

**Instructions:**

Please list and elaborate upon the key people/organizations responsible for this organizational work stream and describe what their responsibilities involve.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program Director</td>
<td>Lidia Virgil</td>
<td>Structure and oversee the implementation of the population health management strategy; Prepare provider engagement plan and oversee population Health campaigns</td>
</tr>
<tr>
<td>Project Manager</td>
<td>Doris Canela</td>
<td>Oversee the implementation of the population health management strategy; reports to the Program Director, Clinical Quality Committee and PPS executive body.</td>
</tr>
<tr>
<td>Medical Director</td>
<td>Dr Jackson Kuan, MD</td>
<td>Provide guidance on protocols and provider and patient engagement strategies. Ensure clinical quality.</td>
</tr>
<tr>
<td>Clinical Quality Committee</td>
<td>Chair: Dr Jackson Kuan, MD</td>
<td>Monitor the impact of DSRIP projects on avoidable hospitalization reduction, changes in inpatient, outpatient, and community capacities; oversee the modeling and implementation of capacity change improvements.</td>
</tr>
<tr>
<td>IT Director</td>
<td>John Dionisio</td>
<td>Lead the development and implementation of the PPS-wide work plan for all relevant providers to achieve PCMH 2014 Level 3 by DY3. Work in coordination with PPS central IT team to ensure population health management IT needs are procured and developed.</td>
</tr>
<tr>
<td>IT Committee</td>
<td>Chair: John Dionisio</td>
<td>Assist in procuring / Developing a robust and functional set of data gathering and monitoring tools and expert analysts</td>
</tr>
<tr>
<td>Provider Engagement</td>
<td>Lidia Virgil</td>
<td>Educate and communicate population health management approach. Communication of strategies on population health management implementation</td>
</tr>
</tbody>
</table>
**Advocate Community Providers, Inc. (PPS ID:25)**

**IPQR Module 8.6 - Key Stakeholders**

**Instructions:**
Please identify the key stakeholders involved, both within and outside the PPS.

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACP CEO (Mario Paredes)</td>
<td>Oversight of DSRIP projects</td>
<td>Jointly responsible for population health initiative implementation and Bed Reduction Plan</td>
</tr>
<tr>
<td>Hospital partners in Advocate PPS Bed Reduction plan (Medisys - Jamaica and Flushing Hospitals, NSLIJ - Lenox Hill and Forrest Hills)</td>
<td>Participate in bed reduction plan and analysis</td>
<td>Represent the Bed Reduction Working Group; will review and advise on any bed reduction goals</td>
</tr>
<tr>
<td>Nursing Homes (CareNext, Various)</td>
<td>Stakeholder to bed reduction plan</td>
<td>Represent the Bed Reduction Working Group; will review and advise on any bed reduction goals</td>
</tr>
<tr>
<td>Behavioral health units / facilities</td>
<td>Stakeholder to bed reduction plan</td>
<td>Represent the Bed Reduction Working Group; will review and advise on any bed reduction goals</td>
</tr>
<tr>
<td>ACP Providers</td>
<td>Adoption of population health management practices</td>
<td>Active engagement of patients and deployment of training and education materials</td>
</tr>
<tr>
<td>CBOs, including organizations focused on social determinants of health</td>
<td>Vital components to ensure success of the population health management strategy – the &quot;glue&quot; services</td>
<td>Work with care management teams to address social determinants of health issues which may be major obstacles for improved health care and health in target population.</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCOs</td>
<td>Key partner in payment reform</td>
<td>Provide insight and partner with Advocate PPS on population health management approach to be implemented across the PPS. They are collaborators in PPS payment reform in line with NYS value based payment (VBP) roadmap.</td>
</tr>
<tr>
<td>Community Leaders</td>
<td>Assist in identifying and achieving target patient outreach and engagement</td>
<td>Assist in providing culturally appropriate and linguistically correct information to the community served by the PPS for population wide campaigns</td>
</tr>
</tbody>
</table>
IPQR Module 8.7 - IT Expectations

Instructions:

Please describe the current Population Health Management IT capabilities in place throughout your PPS network and what your plans are at this stage for leveraging these capabilities and/or developing new IT infrastructure.

Our data and analytics team will be responsible for ensuring practitioners will have timely and useful data and tools readily available to allow them to help develop interventions and services that will address population health issues for their patient population. These will include MAPP, Salient, EHRs, and other platforms to be developed with providers' input. Our participation agreement will require all relevant providers to adopt and use EHRs and achieve MU and PCMH 2014 Level 3 by DY3. Our PCMH / EHR-MU Certification Workgroup will assist providers and systematically implement the plan to achieve MU and PCMH 2014 Level 3 by DY3. ACP's IT integration will also include patient interactive portal for patient engagement and communication, educational materials and referral tracking and appointment assistance. ACP's platform will include data analytics and predictive modeling module that will allow for early intervention and prevention based on aggregate data with standard deviations, algorithmic values and risk assessment. The data obtained will align with patient engagement strategies for each of ACP's DSRIP projects as well as go beyond the projects into a preventive, preemptive, value based practice. ACP's website will contain materials on ACP's population Health projects together with links to community services both state and local through which patients may obtain services including educational and anonymous services.

IPQR Module 8.8 - Progress Reporting

Instructions:

Please describe how you will measure the success of this organizational workstream.

We will monitor the progress and impact of our population health management works stream through a combination of DSRIP outcome measures and specific population health metrics. These will be identified in the Advocate PPS population health roadmap and will be monitored by the Advocate PPS PMO and Clinical Quality Committee. ACP will also use internal and nationally recognized performance measures such as CPTs, claims data, referral tracking and evidence based screenings to monitor engagement, compliance and progress. ACP will also use meaningful use dashboards, EHR and state immunization registries and ERx records to monitor and report progress. Metrics, specific to the two Domain 4 projects that have been selected, will include established rates (smoking rates/100,000, preventive medicine prevalence rates, care gap rates) that are widely available, as well as from internal PPS data derived from physician EHRs. Reporting metrics will be sliced in various ways to create effective population health education plans and outreach campaigns (smoking prevention approach will vary depending on age group, culture, etc). We will build continuous quality improvement into our population health roadmap; establish timeframes for re-evaluation and update of data sets, functionality of registries, and priority issues for population health management. We will certainly identify provider champions and share the knowledge and best practices throughout the PPS network.
IPQR Module 8.9 - IA Monitoring

Instructions:
Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions:

Please enter and update target dates, as well as breakdown tasks with target dates for prescribed milestones. For milestones that are due within the reporting period, documentation is required to provide evidence of milestone achievement. Any explanations regarding altered or missed target commitments must be included within the textbox, not as narrative within uploaded documentation.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone #1</td>
<td>In Progress</td>
<td>Perform a clinical integration 'needs assessment'. Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td>NO</td>
</tr>
<tr>
<td>Task 1</td>
<td>In Progress</td>
<td>1 Perform IT Assessment of Network 1 Survey of all providers to determine electronic record, connectivity, and data sharing capabilities, leverage existing systems where applicable, identify gaps in readiness, staffing, workflows. Create assessment tool to determine readiness and capabilities of providers within the network. Director of IT, John Dionisio, with support from clinical operations team (lead: Lidia Virgil) will be responsible for the conducting of the survey (however potential vendor assistance may be an option). Survey questions are aimed to gather information on partner IT structure (centralized, independent, outsourced), operating system compatibility, EHR type, experience with electronic data feeds, MU/PCMH certification, Care Coordination processes and workflows, patient engagement and communication and information exchange capabilities.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 2</td>
<td>In Progress</td>
<td>2 Review Assessment Results 2 Use survey and assessment tool results to determine capabilities of each individual provider's electronic system for integration; gauge individual provider level of preparedness for EMR and level 3 PCMH certification.</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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</tr>
<tr>
<td>Task 3</td>
<td>In Progress</td>
<td>3 Determine Provider Preparedness Level 3 Determine individual provider level of preparedness for practice workflow restructuring based on current staff and future staff needs, as well as staff educational status and need for retraining. Establish acceptable transition</td>
<td>10/01/2015</td>
<td>03/30/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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</table>
New York State Department Of Health
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<tr>
<td>Milestone #2</td>
<td>In Progress</td>
<td>Develop a Clinical Integration strategy.</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td>NO</td>
</tr>
<tr>
<td>Task 1 Define Project Target State for Clinical Integration</td>
<td>In Progress</td>
<td>1 For each DSRIP project: define with the project group what the target clinical integrated state should look like from a people, process, technology and data perspective (including assessment and care protocols and specific attention to care transitions). Identify the main functional barriers to achieving this from the perspective of both provider organizations and individual clinicians. Currently ACP has been a participating PPS with KPMG in the creation of the TOM system, which has provided a basis for integration.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 2 Determine Gaps Between Current and Target State</td>
<td>In Progress</td>
<td>2 Based on this target state and the gaps identified in the integrated care needs assessment, define and prioritize the steps required to close the gaps between current state and desired end state (in terms of the needs for people, process, technology and data).</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 3 Transition Paper-based Providers and Non-Certified EHR-based to Certified EHR</td>
<td>In Progress</td>
<td>3 Contact providers without EHRs or those with non-certified EHRs as identified in gap analysis and provide contracts for EHR implementation. ACP will support providers and provide assistance and support with implementation of EHR.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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</tr>
<tr>
<td>Task 4 Develop PCMH Implementation Plan</td>
<td>In Progress</td>
<td>4 Contact providers identified in gap analysis and implement plan as in project 2.a.i regarding achievement of PCMH level 3 certification.</td>
<td>10/01/2015</td>
<td>03/30/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>Task 5 Establish Referral Pathways</td>
<td>In Progress</td>
<td>5 Establish referral pathways of integration in which referrals flow between partners in an efficient electronic fashion that can be monitored and in accordance with implemented evidence based protocols and best practices.</td>
<td>10/01/2015</td>
<td>03/30/2016</td>
<td>03/31/2016</td>
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### New York State Department Of Health
### Delivery System Reform Incentive Payment Project
### DSRIP Implementation Plan Project

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<tbody>
<tr>
<td><strong>Task</strong> 6 Identify Common Processes for Each Project</td>
<td>In Progress</td>
<td>6 Identify the common steps required for each project. For example: the need for supportive IT infrastructure to enable data sharing.</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task</strong> 7 Identify Key Clinical Data Required</td>
<td>In Progress</td>
<td>7 Conduct engagement exercise with practitioners and other stakeholders, focused on identifying the key clinical (and other) data that will be required to support effective information exchange at transitions of care.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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<tr>
<td><strong>Task</strong> 8 Create Care Coordination and Provider Education Program</td>
<td>In Progress</td>
<td>8 Create care coordination and provider education program and schedule including training and strategies to use based on provider.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Task</strong> 9 Define Incentives</td>
<td>In Progress</td>
<td>9 Define incentives to encourage the behaviors and practices that underpin the target state (e.g. multi-disciplinary care planning). These incentives might include financial / personnel support to providers looking to improve the efficiency of their operations in order to create more time for coordinated care practices; or the creation of shared back office service functions to improve the efficiency of provider organizations.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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</tr>
<tr>
<td><strong>Task</strong> 10 Clinical Integration Stakeholder Input</td>
<td>In Progress</td>
<td>10 Consult internal and external stakeholders (including patients) on draft clinical integration and transformation strategy.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Task</strong> 11 Finalize Strategy</td>
<td>In Progress</td>
<td>11 Finalize PPS strategy and roadmap document on clinical integration across all projects.</td>
<td>06/01/2016</td>
<td>09/30/2016</td>
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<tbody>
<tr>
<td>Perform a clinical integration ‘needs assessment’.</td>
<td></td>
</tr>
<tr>
<td>Develop a Clinical Integration strategy.</td>
<td></td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
**IPQR Module 9.2 - PPS Defined Milestones**

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
</table>

No Records Found

**PPS Defined Milestones Current File Uploads**

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
</table>

No Records Found

**PPS Defined Milestones Narrative Text**

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
</table>

No Records Found
IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions:

Please describe the key challenges or risks that you foresee in improving the level of clinical integration throughout your network and achieving the milestones described above. Describe potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

IT/EHR Adoption: One of the risks is that some providers may be reluctant to adopt EHRs within tight timeframe to achieve MU 1/2, PCMH Level 3, and to be linked into the clinically interoperable system within the tight timeframe. ACP will provide the providers with support and training through its support center, "hub", in order to help alleviate anxiety and provide efficiency of implementation. Strong provider engagement and buy in is key to this process, therefore the provider engagement team will schedule and run training meetings as well as do individual outreach and surveying of provider status, providing the support teams and governance with readiness and specific action plans.

Referral and Patient Tracking: Another risk is in tracking patient compliance with referrals as coordinated by PCP or specialist providers with such a vast network of providers and such a low health literacy rate we understand that patients tend to seek care through word of mouth in the communities more than through standard evidence based channels. The PPS will mitigate this risk by fostering strong relationships within the community with PCPs, CBOs and providing patient educational campaigns and one on one coaching by the PCP, Care Coordinators and Case managers. The support center, "Hub" care coordination staff will maintain open lines of communication with the patients and provide follow up with them to ensure fulfillment of the referrals and the flow of information to and from PCP and specialty services. The PPS also will use its strength of having such a vast network to ensure that all partners are clinically integrated and have open lines of communication via electronic platform with the ability to share all pertinent patient information so as to track our patients wherever they may receive care. All PPS partners will communicate with central office, (Hub) regarding patient services.

System Integration: Another risk is related to the inadequacy of certain provider's systems for integration. The PPS will mitigate this by creating a platform that is interconnected to many types of systems as well as partnerships with EMR and systems vendors that will provide lower cost systems with stronger support to our partners. The PPS' support center/hub will provide the providers with support, training and assistance. IT policies and process must account for this dependency and create potential workarounds.

IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

Instructions:

Please describe any interdependencies with other organizational workstreams (IT Systems and Processes, Clinical Integration, etc.)

Major dependencies for Clinical Integration are mostly all other aspects of the full implementation plan.

1. Adoption of EHR by all providers is in it's own rite a major dependency since HIE must be timely, efficient and up to the moment.
2. Adoption of PPS clinical protocols and processes by all providers throughout PPS must happen for a successful integration.
3. Governance model must be operational for clear and consistent communication of all providers and follow through, monitoring, incentives for compliance.
4. Clinical integration has a major dependency on workforce strategy. The workforce will need to supply the additional staff needed for
Advocate Community Providers, Inc. (PPS ID:25)

implementation of clinical integration, provider engagement and support center staff as well as current staff retraining.
### IPQR Module 9.5 - Roles and Responsibilities

Instructions:

Please list and elaborate upon the key people/organizations responsible for this organizational workstream and describe what their responsibilities involve.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of IT</td>
<td>John Dionisio</td>
<td>IT Governance, Change Management, IT architecture, data security and confidentiality, data exchange</td>
</tr>
<tr>
<td>Data infrastructure and Security Lead</td>
<td>Rong Zhao</td>
<td>Data security and confidentiality plan, data exchange plan and other operational requirements, both internal and external to the PPS</td>
</tr>
<tr>
<td>HIE Application Lead</td>
<td>Rong Zhao</td>
<td>Application strategy and data architecture</td>
</tr>
<tr>
<td>IT Operations Proj Manage and PCMH</td>
<td>Pabel Medina</td>
<td>Ensure proper controls and protocols are in place for effective day-to-day operational activities including monitoring</td>
</tr>
<tr>
<td>CMO</td>
<td>Dr Jackson Kuan, MD</td>
<td>Ensure proper controls and protocols are in place for effective day-to-day operational activities including monitoring</td>
</tr>
<tr>
<td>Director of Clinical Operations</td>
<td>Lidia Virgil</td>
<td>Structure and Oversee clinical integration requirements from a clinical perspective; Prepare provider engagement plan</td>
</tr>
</tbody>
</table>
### Key Stakeholders

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACP Board (Chairman: Dr Ramon Tallaj, MD)</td>
<td>Approval/Rejection of key initiatives associated with DSRIP program.</td>
<td>Ensure appropriate approvals/rejections of initiatives that directly involve execution of DSRIP programs.</td>
</tr>
<tr>
<td>ACP Directors of Operations (Alexander Damiron, Josephine Wu)</td>
<td>Project Management to ensure sustainability of providers</td>
<td>Management of processes and proposals</td>
</tr>
<tr>
<td>Director of IT (John Dionisio)</td>
<td>Oversight of policies, work groups and deliverables regarding IT</td>
<td>Management of processes and proposals. Ensure clinical project requirements are incorporated into IT solution.</td>
</tr>
<tr>
<td>IT Committee Chair (John Dionisio)</td>
<td>Interface between IT Committee and front line end users</td>
<td>Input into system design, testing, and training strategies</td>
</tr>
<tr>
<td>Director of Workforce (Moises Perez)</td>
<td>Oversight of all training strategies, including practitioner/staff education</td>
<td>Input into practitioner / staff training plan</td>
</tr>
<tr>
<td>Director of Clinical Programs</td>
<td>Lidia Virgil</td>
<td>Ensure clinical protocols are part of business requirements document that will drive IT development</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients (Patient Rep: Ramon Anibal Ramos)</td>
<td>Care improved upon by the clinical integration of the PPS</td>
<td>Response to consultation on clinical integration strategy</td>
</tr>
<tr>
<td>Patient Family members and Caregivers</td>
<td>Communication with practitioners, particularly on behalf of children, the elderly, or those without mental capacity</td>
<td>Response to consultation on clinical integration strategy</td>
</tr>
<tr>
<td>EHRs vendors</td>
<td>Partner in EHRs and HIE solutions</td>
<td>EHRs and HIE solutions that meets DSRIP requirements for integrated delivery system, connectivity and interoperability</td>
</tr>
</tbody>
</table>
IPQR Module 9.7 - IT Expectations

Instructions:

Please clearly describe how the development of shared IT infrastructure across the PPS will support this particular workstream.

Key elements of the IT infrastructure include the adoption of EHRs by all participating providers, and the achievement of PCMH Level 3, as well as the development of interconnectivity platform for HIE. Full EHR connectivity will enable electronic linkage and sharing of pertinent data on a common platform. ACP will also connect to RHIO / SHIN-NY for more effective HIE and reporting throughout and across all PPS’. Until full EHR / HIE connectivity is achieved, ACP has developed alternate internal HIE systems and processes and will utilize State platforms such as MAPP and Salient to share milestone and metric progress and analytics PPS wide. This will be supplemented with our own performance metrics and analytics. ACP will use its support center, which includes IT support teams, to provide support to all of our providers to report on all clinical and quality measures. The IT teams will provide support with EHR, PCMH, interconnectivity and data exchange. While our platform is being finalized, we will use a mix of manual and electronic methods, such as HIEs that are available from our EMR vendors. We will adhere to the DSRIP’s requirements and protocols for data sharing and confidentiality. We have had successful pilots with three of our partner hospitals in secure messaging and alerts for ED and hospital admission / discharge / transfer (ADT) and will be able to deploy this for all of our network providers. While we await the availability of the State’s Health Home platform and RHIO platforms, we will use patient and physician portals that are associated with our current major EHR vendors used by our network providers.

IPQR Module 9.8 - Progress Reporting

Instructions:

Please describe how you will measure the success of this organizational workstream.

ACP will develop monitoring metrics which will be run periodically to measure success of the processes. Process success will be measured based on patient information exchange and efficiency of providing services to patient as referred by all ACP providers. Measures will include effective communication between providers as well as HIE. Performance monitoring will include completion and receipt of referral reports as well as the turnaround time for these. Success and the integrity of the process will also be measured based on MU dashboard data which will show proper use of the EMR, also via Care Coordination platform measuring patient outreach and compliance also being used for PCMH certification. Metrics to be measured and tracked include: referral close rates ('referral aging schedule' to measure response time and actual close rate percentages), patient engagement rates, care plan compliance, etc. for all providers and especially for CBOs (CBO role in entire process is crucial to ensure patients receive adequate social supports). Other typical metrics will include admission, re-admission and ED utilization rates to ensure that those who do have high utilization are outreachted to and provide care management.
New York State Department Of Health
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Instructions:
Section 10 – General Project Reporting

IPQR Module 10.1 - Overall approach to implementation

Instructions:

Please summarize your intended approach to the implementation of your chosen DSRIP projects, including considerations around how this approach will allow for the successful development of concurrently implementing DSRIP projects.

ACP’s network requires alignment of a range of providers to ensure the PPS’s performance meets milestones, goals of the projects and overall goals of DSRIP. Each project will have its own leadership with clinical and operational leads, representative of the service providers involved and will be responsible for project management, tracking and monitoring progress toward milestones and metrics at all levels, ensuring compliance with project requirements, speed and scale, and reporting the progress on these to the workstream directors and Clinical Quality Committee. The project team will also oversee the development of provider/staff/patient education, training and support, and ensuring adherence to Clinical Committee guidelines. Medical Directors will be responsible for providing support to providers and their patients by providing care coordination, care management, education, training, and outreach. The staff for care coordinators, care managers, outreach staff are consistent with workforce streams.

ACP will use internal and State platforms for continuous education and communication. In addition, all leadership and participating providers will be encouraged to participate in workgroups and collaborative learning groups. We will build on our existing IPA/ACO regional physician engagement teams and meet monthly/quarterly. Experience has found that peer education is a key component for maintaining meaningful engagement among physicians. We will use a platform for data sharing to empower providers with information for clinical decision making, behavior change, and performance achievement. This platform is being put together in Project 2.a.i and will have connectivity and real-time exchange in addition to connectivity with RHIO/SHINY and other state reporting sites such as Salient.

In addition to the general framework for DSRIP, ACP intends to approach project implementation in several ways. All projects will follow:

1. Creation and implementation of evidence-based protocols. ACP has developed and drafted evidence-based and process manuals to support quality treatment of its patients and a consistent approach to care. Each protocol also has been condensed into shorter summaries for easier approach and understanding by providers.

2. Creation of a support center who will provide ongoing support to all of ACP’s providers. This will consist of IT Support, Outreach, Care Coordination/Management, and Reporting/Analytics staff.

3. ACP has Physician Engagement teams who shall be the first line of communication with providers and staff to provide ongoing outreach and training. The Physician Engagement teams will be comprised of staff of the same culture and regional area as the providers. The processes will provide the tools that providers need to be successful without implementing new workflows on their own. Many times the providers treat all of the conditions addressed in the DSRIP projects in a vacuum and without support, causing them to not being able to provide close monitoring and follow up. ACP’s implementation plan takes the providers current workflows and promotes higher rates of compliance and quality care.

4. The project implementation process will be guided and overseen by Directors and the clinical quality committee. Progress will be monitored through metrics developed by ACP for reporting which will include MU and PCMH quality reporting as well as claims data, CDSS alerts and other ACP quality metrics.

5. Throughout all of ACP’s projects, ACP will work collaboratively with all other PPS and will include joint campaigns for population health, health
Many interdependencies exist between ACP’s DSRIP projects. These interdependencies live in the major IT infrastructure that ACP is developing with an interconnected IT platform that will allow for real-time data sharing between providers and fostering of exquisite care coordination. A care coordinator and PCP staff will be able to follow a patient from the point of initial contact through the referral and consult back process, never losing site of the patient status and care. All PCPs will attain PCMH level 3 status thus improving the quality of care and care coordination of their patients. ACP’s protocols are comprehensive and extensive and cover many often-missed elements of disease care which involve and intertwine with care for comorbid conditions also addressed in other of ACP’s DSRIP projects. Several of the projects being implemented by ACP have several synergies in their treatment plans and approaches to care and many patients have comorbidities corresponding with the disease specific projects being implemented. ACP plans to capitalize on these synergies to avoid duplications and create more efficient treatment of patients and increased patient engagement. ACP will have staff that is trained in several aspects of care and not just one project, to address those patients with comorbidities, or more than one condition pertaining to more than one of our projects. For example a Diabetic who also has Hypertension and who will receive Lifestyle coaching and disease management techniques for both diseases will receive care from one PCP and be followed by the same care coordination and case manager. This alignment creates a greater rapport between the patient and the practice/staff and translate into increased compliance.

With respect to overlapping project requirements, we have mapped these out in a matrix format showing the cross-cutting of requirements. For those project requirements that are most pervasive, we have set up specific work teams tasked with ensuring consistent and coordinated implementation. The achievement of PCMH 2014 Level 3 certification is one example - we have a dedicated PCMH / EHR-Meaningful Use (MU) team that will be responsible for assisting all relevant providers to meet this project requirement according to the timetable set out in speed and scale commitments. This work team will be responsible for the overlapping requirements of using EHRs to track all patients engaged in projects and ensure all EHR systems used by participating safety-net providers meet MU and PCMH Level 3 by the end of DY3.

The Clinical Quality Committee will also work collaboratively with other work stream committees to ensure activities are complementary and supplementary to their activities as there are dependencies among them. We will depend on IT systems and processes for our data sharing communications strategies, clinical integration, and timely performance reporting for rapid cycle evaluation. Access and understanding analytics will help in more accurate population health management.
### IPQR Module 10.3 - Project Roles and Responsibilities

**Instructions:**
Please outline the key individuals & organizations that play a role in the delivery of your PPS's DSRIP projects, as well as what their responsibilities are regarding governance, implementation, monitoring and reporting on your DSRIP projects.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York State Department of Health</td>
<td>Peggy Cheng</td>
<td>Provide guidance for project implementation, metrics and reporting Funds - payments for goal attainment</td>
</tr>
<tr>
<td>Board of Directors</td>
<td>Chairman: Dr Ramon Tallaj MD</td>
<td>Oversight and performance evaluation feedback Provide necessary funds for project implementation</td>
</tr>
<tr>
<td>ACP CEO</td>
<td>Mario Paredes</td>
<td>Oversee all management functions, Staffing Organizational functions Assist in funds distribution</td>
</tr>
<tr>
<td>Clinical Committee</td>
<td>Chair: Dr Jackson Kuan, MD</td>
<td>Provide oversight and advise on clinical elements of project implementation Advisory on clinical protocols, process and procedure manuals</td>
</tr>
<tr>
<td>IT Committee</td>
<td>Chair: John Dionisio</td>
<td>Provide oversight on clinical integration for project implementation Review IT proposals, vendors and IT security Provide advisory on selections</td>
</tr>
<tr>
<td>CMO</td>
<td>Chair: Dr Jackson Kuan, MD</td>
<td>Provide guidance on clinical protocols and oversight in all clinical projects, evaluate performance and provide feedback and implement corrective action plan for low performers.</td>
</tr>
<tr>
<td>IT Director</td>
<td>John Dionisio</td>
<td>Assist in creation of HIE platform, attainment of PCMH level 3 certification for all PCPs and EMR implementation for all practitioners Plan for successful implementation of EMR, PCMH certification and HIE interconnectivity platform.</td>
</tr>
<tr>
<td>Workforce Director</td>
<td>Moises Perez</td>
<td>Analyze staffing necessary for implementation of each project and success. Provide oversight and guidance on staffing needs Identify retraining and new staff needs.</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>Several, God's Love we Deliver, Association of People with Developmental Disabilities</td>
<td>Assist in providing necessary services to patients including social services and community engagement</td>
</tr>
<tr>
<td>Patient / User Groups</td>
<td>Ramon Anibal Ramos</td>
<td>Ensure the patient view and insight drive project strategy and implementation.</td>
</tr>
<tr>
<td>TEF (Sandi Vito)</td>
<td>Workforce Training and Redeployment</td>
<td>Participate on Workforce Training and Redeployment issues, agreements and documents.</td>
</tr>
<tr>
<td>NYS DOHMH &amp; Divisions</td>
<td>Gary Belkin</td>
<td>Provide resources and insights into project implementation and standards of care and best practices.</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Union (Helen Schaub)</td>
<td>Labor representation</td>
<td>Participate on Workforce issues, agreements and documents,</td>
</tr>
</tbody>
</table>
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

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**IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects**

**Instructions:**

In the below table, please set out who the key stakeholders are that play a major role across multiple DSRIP projects. Please give an indication of the role they play and how they impact your approach to delivering your DSRIP projects.

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| ACP Primary Care Providers | Primary Care Providers | Implementation of clinical protocols  
Implementation of EHR  
Attainment of PCMH level 3 certification |
| Hospital partners | Medisys (Bruce Flanz) and NSLU (Grace Wong) | Participate interconnectivity for efficient HIE  
Implement hospital based projects  
Work closely with PCPs and Health Homes to foster greater PCP/patient interaction and loyalty to achieve DSRIP goals |
| General Project Manager/Director of Programs | Lidia Virgil | Written process and procedure manuals for implementation, periodic metrics reports analysis |
| IT Director | John Dionisio | Contact all providers with EMR implementation proposal  
Assist in PCP PCMH certification implementation plan  
Develop IT platform for integration and interconnectivity |
<p>| Clinical Quality Committee | Chair: Dr Jackson Kuan, MD | Provide oversight and guidance on all project implementation protocols and metrics. Evaluate provider performance toward achievement of goals. |
| Finance Committee | Chair: Bruce Flanz | Provide financial analysis and plan to fully support project implementation with proper staffing levels, well designed incentives and access to funds for infrastructure |
| Workforce Director | Moises Perez | Provide workforce roadmap to achieve a competent and efficient workforce that provides support and needed services to achieve successful project implementation |
| <strong>External Stakeholders</strong> |
| MCOs | Data source | Ensure interface compatibility and consistency of data feeds |
| EHRs vendors | Partner in EHRs and HIE solutions | EHRs and HIE solutions that meet DSRIP requirements for integrated delivery system, connectivity and interoperability |
| NY DOH and other state/city agencies | Oversight of Safety Net providers | Ensure Safety Net providers continue to operate to provide services to Medicaid patients. Ensure timely payments to prevent cash flow issues with PPS. Ensure reimbursement policies follow VBP roadmap guidelines that positively impact provider billing |</p>
<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate Community Providers, Inc. (PPS ID:25)</td>
<td></td>
<td>practices (ie FFS transition to Level III VBP). Ensure PCMH reimbursement program continues to assist physicians with upkeep of PCMH certifications.</td>
</tr>
</tbody>
</table>
IPQR Module 10.5 - IA Monitoring

Instructions:
Project 2.a.i – Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management

IPQR Module 2.a.i.1 - Major Risks to Implementation and Mitigation Strategies

Instructions:

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

1. IDS: ACP providers have been independent and the change to an IDS (IDS) might be a risk. We intend to educate a shared vision at all levels, from the Board down to participating providers and their staff. Provider buy-in will be developed through communication and education and ongoing support to will be available. Sufficient budget dollars and workforce are critical to support the IT plans for an IDS. Funds flow will also motivate providers to change practice and workflow behaviors. Additionally, while many use cases have been projected, there could be scenarios that may not have been considered. The PPS will have back-up processes in place in case of a gap in the system, including manual work-arounds and web-based portals to securely send information with providers and care managers.

2. Budget: the wide scope requires a budget that can accommodate project implementation. Funds flow allocated toward building an IDS needs to be sufficient to cover the ‘must-have’ items. The PPS has a contingency line item in the budget that can accommodate potential costs not currently specifically budgeted.

3. Patient compliance and engagement: the PPS will need to find creative ways to ensure patient compliance and engagement. Current efforts by the providers and health plans have some impact, but still find that many patients do not seek care in clinically appropriate settings. The PPS has to work closely with all providers to ensure proper identification and engagement of patients are effective. Literature suggests that high levels of patient satisfaction leads to improved patient engagement. The PPS can assess and identify barriers that prevent patient satisfaction to assist with improvement of patient engagement.

4. Provider Culture: providers' ability and time to document a disease-specific, personalized care plan for each patient with an at-risk chronic illness could be a potential risk. This will require additional time with the patients to provide, not only, a written care plan and sufficient documentation, but also educating the patient on the importance of plan compliance. ACP plans to mitigate by providing support at the provider level. This support includes care teams that are culturally competent, which include other practitioners, BH providers, pharmacists, nurse educators and care managers. In addition, ACP has developed electronic versions of disease specific care plans that can be personalized within the EMR to provide trackable documentation. This will assist providers in billing for complex care management services for their additional time and effort per patient. Also, given the unique structure of our PPS that spans more than 2,000 physicians and community based providers, communication and information sharing could be a challenge. ACP is reaching out and discussing possible collaborations with all of the hospitals in ACP's catchment area and those which any ACP attributed patient may receive services.

5. PCMH Certification Requirement: an additional risk is PCP compliance with level 3 PCMH certification. As referenced in the second risk, ACP has developed templates within the EMR minimizing the time that it will take providers to complete.

6. Physician/Patient Relationship: many cultures are biased towards going to the emergency department (ED) for care, as it is seen as more convenient and immediately responsive than a PCP visit. Our PPS will provide education and awareness to emphasize connecting to a PCP and working with community organization partners to expand outreach into the ethnic groups represented in the population. Additionally, the ED triage process will include a team of Patient Navigators available to every patient to satisfy project requirements such as ensuring appointments prior to ED discharge, with the intent of connecting to a PCP and reduce avoidable ED visits.
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- **IPQR Module 2.a.i.2 - Project Implementation Speed**

**Instructions:**

Please specify how many providers will have met all of the project requirements (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.

Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>902</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>1,428</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospitals</td>
<td>13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinics</td>
<td>43</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>130</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>34</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Skilled Nursing Facilities / Nursing Homes</td>
<td>32</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospice</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>1,418</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>4,034</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

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In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
### Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
### Milestone #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.

<table>
<thead>
<tr>
<th>Task</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Develop participation agreement language for each provider type requiring mandatory participation in the ACP Integrated Delivery System. Assess feasibility of developing borough-level organization regarding communication and large-scale implementation, such as integrated delivery system or the population health projects. ACP PPS is community-based and community-physician led. A majority of our community partners have been included because the Medicaid patients assigned to our physicians use the physicians within the network. Thus, these providers have been included in large scale within ACP’s network and will continue to assist the providers and the patients in providing appropriate medical care and social support. Additionally, most community-based provider types (including Mental Health, Substance Abuse and Social Supports) will be included in the PPS network.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td>2 Establish a Project 2.a.i. Leadership Team with roles and responsibilities to take a leadership role on this project. Project will be co-led by the Director of Clinical Operations, Lidia Virgil and Director of IT, John Dionisio. Team will include expertise from all areas (IT and IT security, Clinical Operations, Workforce [Moises Perez], Compliance (Tom Hoering), amongst others) and will require support from providers and staff. Additionally, because of the heavy dependencies on IT, support from physician EHR vendors will also be key in the success of the creation of an integrated delivery system.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
</tbody>
</table>
3 Develop Project 2.a.i. Roadmap with timeline which would include flexibility to be reviewed and updated at least annually and ability to explore adding potential partners (including social service organizations/CBOs). The roadmap will incorporate any IT assessments derived from the IT milestones, determine future state and propose solutions to achieve the target state. The roadmap will consider the connectivity needs of all provider types (including Mental Health, Substance Abuse and Social Supports) to create an integrated solution.

<table>
<thead>
<tr>
<th>Task</th>
<th>4 Finalize (including ACP Board approval) Project 2.a.i. Roadmap with timeline, including timeline for provider contracting with partners within the organization.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>PPS produces a list of participating HHs and ACOs.</td>
</tr>
<tr>
<td>Task</td>
<td>Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.</td>
</tr>
<tr>
<td>Task</td>
<td>Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.</td>
</tr>
<tr>
<td>Task</td>
<td>Identify key Health Homes and ACO partners to create workgroup (include discussions with relevant committees, for example, IT Committee on integrating IT capabilities)</td>
</tr>
<tr>
<td>Task</td>
<td>Develop matrix of core capabilities of partnering Health Homes and ACOs, including provider services, IT assessments, etc. Matrix, as part of roadmap, should identify strengths and weaknesses of existing systems and processes. IT integration solution shall incorporate existing system strengths (strong network, structured communication processes, referral tracking, care management capabilities, strategies regarding patient compliance) and complement weaknesses (manual workarounds, workflow gaps, resource gaps, IT shortfalls).</td>
</tr>
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</table>
| Task | Develop strategy for partnering with Health Home and ACO population management systems and capabilities that incorporates roadmap and matrix developments. Leverage existing effective processes and understand components that are needed to scale processes to broader network. Introduce

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
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<th>End Date</th>
<th>Quarter End Date</th>
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<tr>
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<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>Task</td>
<td>PPS produces a list of participating HHs and ACOs.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td>Task</td>
<td>Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
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<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
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<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
</tbody>
</table>
### Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
Centralized processes that the PPS will manage to assist with expanding scale. |  |  |  |  |  |  |  
**Task**
4 Finalize strategy and incorporate into Project 2.a.i Roadmap with timeline, with flexibility to be reviewed and updated at least annually. Flexibility of design will allow for continuous system improvement that will maximize impact within network. | Project | In Progress | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |  
Milestone #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. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |  
**Task**
Clinically Interoperable System is in place for all participating providers. | Project | In Progress | 01/01/2016 | 03/31/2017 | 03/31/2017 | DY2 Q4 |  
**Task**
PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS. | Project | In Progress | 10/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |  
**Task**
PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed. | Project | In Progress | 10/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |  
**Task**
PPS trains staff on IDS protocols and processes. | Project | In Progress | 01/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 |  
**Task**
1 ACP needs to understand the population it serves in order to ensure appropriate care is provided. Categorize ACP attributed beneficiaries into stratified risk groups using a common model (e.g., HCC, John Hopkins, 3M) and identify priority disease conditions for each category (based on State provided data on ACP's attributed beneficiaries, claims data from MAPP, Salient, IPAs' ACOs' data from MCOs and Medicare, and providers' EHRs / medical record data). The data can come from variety of sources, including State, MCO and physician EHR. Stratification then allows PPS to understand and develop specific interventions that can positively impact patients (High-risk patients will require extensive, coordinated care. Moderate-risk patients will require some care, but as important, should received proper care that keeps the patient at moderate-risk status or potentially drop to low-risk status if possible [goal is to prevent patient from entering high-risk status]. Low-risk patients will need to receive preventive care to ensure that this cohort remain low-risk and does not move up to moderate or high-risk status.). Stratification algorithm based on common models can be developed/formalized in concert with PPS analytics team that is being assembled. | Project | In Progress | 01/01/2016 | 06/30/2016 | 06/30/2016 | DY2 Q1 |  
**Task**
Project | In Progress | 01/01/2016 | 06/30/2016 | 06/30/2016 | DY2 Q1 |  

NYS Confidentiality – High
## Project Requirements

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
<td>2 Review and adopt clinical protocols from PPS's selected Domain 2,3 and 4 projects for priority disease conditions among ACP attributed members. Protocols outline care steps that will guide physicians to ensure appropriate health care is provided. If required, appropriate community and social supports will be included in care plans to ensure member receives holistic (or whole-person) care. ACP's leadership and network safety-net community partners understands the population that it serves often require more than medical care. Supports from CBOs, Mental Health/Substance Abuse organizations, post-acute care such as Skilled Nursing Facilities and some Nursing Homes, long-term care providers and public health services are key to ensuring care is provided and maintained in between physician visits.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td>3 Develop a directory of available resources (includes typical and atypical providers types). Typical providers types are those who provide medical care such as physicians, clinics, hospitals, behavioral health, substance abuse, etc. Atypical providers are those who address socio-economic factors such as housing agencies, community-based organizations and social services. These resources can provide services based on the clinical protocols for care coordination needs and address gaps that are delivered in appropriate settings.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td>4 Identify additional provider type gaps based on resource directory and take necessary action to fill those gaps looking at all provider types, such as reaching out to CBOs and providers for participation in ACP. Network will continue to evolve as ACP's members' needs change. It is important to ensure patients needs are continually monitored to ensure appropriate care is given. Stratification step (step 1) will be completed periodically to ensure that the appropriate provider types are available.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>5 Develop system to engage patients with PPS using variety of methods such as patient navigators, community health workers, or access to patient portals that allow for a systematic way of communication between PPS, its partners and the patient requiring care. Currently, many agencies conduct patient outreach, however there is opportunity to improve patient engagement. ACP will assess creative yet practical ways to engage with patients including electronic outreach (smart phone apps, telephonic/text reminders) and community-based outreach (outreach to caregivers). PPS will also utilize patient satisfaction survey tools to assess ways to improve patient satisfaction (high levels of patient satisfaction has shown high levels of compliance) to</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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Advocate Community Providers, Inc. (PPS ID: 25)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>Provider Type</th>
<th>Status</th>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>improve patient compliance.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 6 Finalize ACP care coordination strategy to include structure, roles, responsibilities, services, policies and procedures, with linkages to other work streams as detailed in the ACP projects implementation plan. ACP plans to centralize its care coordination function (while leveraging existing effective care coordination processes within its network) where referral management and patient engagement strategies are key roles. Care coordination is a core function within an integrated delivery system - sufficient resources, tools and support, workflows and strategies will be included in the final roadmap. Support from other workstreams such as IT (ensure technology enables communication and the coordination), clinical operations (ensure protocols provide appropriate evidence-based care pathways for physicians to follow), workforce (appropriate training and re-training is provided so that the process is followed), and practitioner engagement (ensure physicians understand their roles with the provision of care) will assist with effective care coordination.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 7 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely to patients. Processes will be developed to track progress, including providing feedback that allow for process improvement. Metrics to assist with measuring timely delivery of services include: Referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2016</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 8 Begin implementation of ACP projects implementation plan which includes tracking that patients receive appropriate support and care. This can be performed in various ways, such as understanding care gaps and outreaching to patients to close. PCMH, a major component of this project, specifically outlines various clinical care process improvement requirements involving immunization, preventive care and chronic or acute care measures.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>Milestone #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.</td>
<td>Project</td>
<td>N/A</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>Task EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td>Task</td>
<td>EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
<td>Reporting Level</td>
<td>Provider Type</td>
<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
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<tr>
<td>Provider</td>
<td>Safety Net Non-PCP Practitioners</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Provider</td>
<td>Safety Net Hospitals</td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
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<tr>
<td>Provider</td>
<td>Safety Net Behavioral Health</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Provider</td>
<td>Safety Net Skilled Nursing Facilities / Nursing Homes</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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</tbody>
</table>

- Task 1: Establish work plans with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR.
- Task 2: Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feed into HIE.
- Task 3: Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.
- Task 4: Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.
- Task 5: Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.
- Task 6: Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.
- Task 7: Develop final plan for sharing health information among clinical partners by DY3.
- Task 8: Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.
<table>
<thead>
<tr>
<th>Milestone #5</th>
<th>Reporting Level</th>
<th>Provider Type</th>
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<th>Start Date</th>
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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>Ensure that EHR systems used by participating safety net providers meet</td>
<td>Project</td>
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<td>In Progress</td>
<td>07/01/2015</td>
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<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Meaningful Use and PCMH Level 3 standards and/or APCM by the end of</td>
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<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU</td>
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<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<td>requirements adjusted by CMS will be incorporated into the assessment</td>
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<tr>
<td>PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>1 Survey and group all participating safety net providers into level of</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>2 Develop plan, timelines, and assign resources for each level of readiness.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>This includes PPS-defined readiness levels with strategies that will vary</td>
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<td>based the different levels (ie those who are technologically integrated will</td>
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<td>have a different approach than providers who are still utilizing paper</td>
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<tr>
<td>3 Establish communications / marketing plan and outreach to all ACP safety</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<td>net providers that also identifies support resources.</td>
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<tr>
<td>4 Start to implement plan to ensure safety net providers achieve MU/PCMH</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Level 3 by end of DY3. Implementation plan includes support from resources</td>
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<td>including PCMH CCEs. Support may include internal or external resources.</td>
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<td>DY2 Q4</td>
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<tr>
<td>Perform population health management by actively using EHRs and other IT</td>
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<td>platforms, including use of targeted patient registries, for all participating</td>
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<td>safety net providers.</td>
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<td>PPS identifies targeted patients through patient registries and is able to</td>
<td>Project</td>
<td></td>
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<td>03/31/2017</td>
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<td>DY2 Q4</td>
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<td>track actively engaged patients for project milestone reporting.</td>
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<tr>
<td>1 Refine priority of clinical issues from CNAs to include specific</td>
<td>Project</td>
<td></td>
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<td>04/01/2015</td>
<td>12/31/2015</td>
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<td>DY1 Q3</td>
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<td>priorities by geographic areas and ensure alignment between projects</td>
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<td>undertaken.</td>
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<tr>
<td>2 Create a database for program planning (expand on data collected as part of</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<td>our CNA)</td>
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<tr>
<td>3 Review adopted clinical protocols, care guidelines, established performance</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
</tbody>
</table>
### Project Requirements

#### Task 1: Develop a population health database that is able to drill down at all levels using data from various sources, such as EHRs (with bi-directionally capable HIE)
- **Reporting Level:** Project
- **Provider Type:** In Progress
- **Start Date:** 07/01/2015
- **End Date:** 03/31/2016
- **Quarter:** DY1 Q4

#### Task 2: Perform data analyses to identify priority clinical issues and establish registries.
- **Reporting Level:** Project
- **Provider Type:** In Progress
- **Start Date:** 07/01/2015
- **End Date:** 06/30/2016
- **Quarter:** DY2 Q1

#### Task 3: Develop process to access individual provider EHRs and use registries to understand disease-specific drivers that will lead to population health initiatives.
- **Reporting Level:** Project
- **Provider Type:** In Progress
- **Start Date:** 07/01/2015
- **End Date:** 06/30/2016
- **Quarter:** DY2 Q1

#### Task 4: Complete workforce assessment for care management capabilities among all participating safety net providers, including staff skills and resources required to manage priority at risk populations in each geographic area.
- **Reporting Level:** Project
- **Provider Type:** In Progress
- **Start Date:** 07/01/2015
- **End Date:** 03/31/2016
- **Quarter:** DY1 Q4

#### Task 5: Develop workforce training / re-training / support staff assignment to mitigate workforce gaps.
- **Reporting Level:** Project
- **Provider Type:** In Progress
- **Start Date:** 07/01/2015
- **End Date:** 03/31/2016
- **Quarter:** DY1 Q4

#### Task 6: Deploy staff support at provider level to train providers and staff on how to use and apply information learned from registries; how to establish care guidelines, develop disease pathways and inform on metrics for monitoring progress in managing population health.
- ** Reporting Level:** Project
- **Provider Type:** In Progress
- **Start Date:** 07/01/2016
- **End Date:** 03/31/2017
- **Quarter:** DY2 Q4

#### Milestone #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.
- ** Reporting Level:** Project
- **Provider Type:** N/A
- **Start Date:** 07/01/2015
- **End Date:** 03/31/2018
- **Quarter:** DY3 Q4

#### Task 7: Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.
- ** Reporting Level:** Project
- **Provider Type:** In Progress
- **Start Date:** 01/01/2016
- **End Date:** 03/31/2018
- **Quarter:** DY3 Q4

#### Task 8: All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.
- ** Reporting Level:** Provider
- **Provider Type:** Primary Care Physicians
- **Start Date:** 07/01/2015
- **End Date:** 03/31/2018
- **Quarter:** DY3 Q4

#### Task 9: EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)
- ** Reporting Level:** Project
- **Provider Type:** In Progress
- **Start Date:** 07/01/2015
- **End Date:** 03/31/2018
- **Quarter:** DY3 Q4

#### Task 10: NYS Confidentiality – High

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New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc. (PPS ID:25)
<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Survey and group all participating providers (safety net and non safety net) into level of readiness.</td>
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<tr>
<td><strong>Task</strong> 2 Develop plan, timelines, and assign resources for each level of readiness.</td>
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<td>In Progress</td>
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<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td><strong>Task</strong> 3 Clinical governance committee approves partner assessment results and PCMH roadmap.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task</strong> 5 Implement plan.</td>
<td>Project</td>
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<td>04/01/2017</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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</tr>
<tr>
<td><strong>Task</strong> 6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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</tr>
<tr>
<td><strong>Milestone #8</strong> Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.</td>
<td>Project</td>
<td>N/A</td>
<td>10/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> Medicaid Managed Care contract(s) are in place that include value-based payments.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 1 Complete value-based payment arrangement assessment at each IPA (each IPAs to review its respective list of existing contracts with MCOs and other payers and identify and explore opportunities for value-based payment arrangements). Leverage activities from Financial Sustainability workstream regarding contracting with MCOs regarding VBP. Lastly, assessment results will determine best options to take for establishing VBP contracts.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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</tr>
<tr>
<td><strong>Task</strong> 2 Establish ACP Financial Sustainability/VBP committee to explore ACP contracts with MCOs and other payers on value-based payment arrangements.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task</strong> 3 Develop ACP value-based payment roadmap. Roadmap, similar to New York State Roadmap for Medicaid Payment Reform (&quot;A Path toward Value Based Payment&quot;), cohorts need to be established to understand which methodologies will be the most appropriate. All Care for Total Population Option may not be the optimal option initially, especially for high risk</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<td>Project Requirements (Milestone/Task Name)</td>
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<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
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<td>subpopulations or populations where bundling might be a better option, however it is expected to achieve level 3 VBP regardless of VBP type. Currently, the IPAs are under a capitated/FFS with risk sharing (All Care for Total Population Level 2). The IPAs are familiar with this concept and with appropriate reporting (to emphasize focus on outcomes) and support, the groups can effectively transition into Level 3. For other providers, the other VBP options will be discussed directly and recommendations presented as to how each provider type (BH, SUD, SNF, Hospital, Health Home, CBOs, etc) will be compensated.</td>
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<td>In Progress</td>
<td>10/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td>Task 4 Approve ACP value-based payment roadmap.</td>
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<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Milestone #9</strong> Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.</td>
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<td>DY2 Q3</td>
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<tr>
<td>Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.</td>
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<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td>Task 1 Identify MCOs.</td>
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<td>Task 2 Establish committee.</td>
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<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 3 Develop committee charter, goals, meeting schedules, etc.</td>
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<tr>
<td>Task 4 Conduct monthly meeting with MCOs to discuss utilization trends, performance issues, and payment reform issues.</td>
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<td>DY2 Q3</td>
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<tr>
<td>Task 5 Initiate VBP transition plan including interim steps and complete by DSRIP timelines.</td>
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<td><strong>Milestone #10</strong> Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.</td>
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<tr>
<td>Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation</td>
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<td>09/30/2016</td>
<td>DY2 Q2</td>
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<tr>
<td>Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.</td>
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<td>12/31/2017</td>
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<td>Provider Type</td>
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<td>End Date</td>
<td>Quarter End Date</td>
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<tr>
<td>1</td>
<td>Establish committee (committee will include expertise from other workstreams such as Clinical Programs (Lidia Virgil), Compliance (Tom Hoering), Finance (Wallace Lau), IT (John Dionisio). The IPA leadership (Ramon Tallaj, MD, Henry Chen, MD, Emilio Villegas, MD) will play a role with physician engagement. Other providers such as hospitals (NSLIJ and Medisys Hospital System) will also represent. The PAC will also be engaged as they represent the overall network (including post-acute care providers, CBOs, BH and SUD, etc). Lastly, the MCOs will need to be part of this committee or play an advisory role to ensure the VBP levels and options are operationally feasible and to establish appropriate timelines based on DSRIP commitments.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td>2</td>
<td>Develop committee charter, goals, meeting schedules, work plan, deliverables and timelines.</td>
<td>Project</td>
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<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td>3</td>
<td>Approve a roadmap for transition towards value-based payment by aligning provider compensation to patient outcomes. Performance reporting is a major component to VBP. MCOs will need to provide adequate data and reporting to tie practitioner performance to patient outcomes.</td>
<td>Project</td>
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<td>01/01/2016</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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<td>4</td>
<td>Conduct meeting(s) with safety net providers to obtain comments, ideas, suggestions, obstacles, issues, possible solutions. VBP approach is key with a large network with a wide spectrum of provider types. MCO contracting will need to ensure VBP approach is appropriate.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
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<td>12/31/2016</td>
<td>DY2 Q3</td>
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<td>5</td>
<td>Conduct meeting(s) with MCOs to ensure needs are addressed, such as appropriate contracting language, data exchange and benchmark info that will determine goals.</td>
<td>Project</td>
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<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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<td>6</td>
<td>Develop potential models that adhere to roadmap guidelines that are appropriate to cost categories (total population care vs sub-population care vs bundling, etc). The various physician groups within ACP has familiarity with risk contracting and capitation models that could help facilitate the transition to VBP.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<td>7</td>
<td>Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and finalize contracting points and terms with MCOs.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>8</td>
<td>Implement plan and establish monthly/quarterly meetings to ensure VBP</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2017</td>
<td>12/31/2017</td>
<td>12/31/2017</td>
<td>DY3 Q3</td>
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### Project Requirements (Milestone/Task Name)

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<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tr>
<td><strong>Milestone #11</strong></td>
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<tr>
<td>Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.</td>
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<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
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<tr>
<td>1 Establish patient engagement committee.</td>
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<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>2 Establish committee charter, work plan, milestones, timelines.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
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<tr>
<td>3 Develop an IDS patient engagement plan that is culturally appropriate. Plan should also include assessment of health literacy of patients so initiatives can be developed to address potential health literacy barriers. Socio-economic factors should be considered so that medical needs become a priority for patients. Use of community health workers, peers, advocacy groups, families and caregivers can supplement traditional outreach methods (such as mailers or telephonic outreach). These groups are typically from the same community, culturally competent and can be trained to have high levels or health literacy to convey messages effectively. In addition, community-based organizations have grassroots level reach to members and can assist with engagement with the providers within the PPS. Lastly, plan should include assessment of patient satisfaction. As previously mentioned, high levels of patient satisfaction can lead to higher levels of patient engagement.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
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<td>4 Develop potential models and design, including development of workforce requirements, such as training or re-training community health workers, peers, advocacy groups and CBOs. Because ACP is a physician-led, community-based PPS, it has wide array of provider types that it can leverage to engage patients in very culturally appropriate ways. Aligning these resources will assist with effective outreach and patient engagement.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/01/2017</td>
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<td>5 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely and patients remain engaged.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
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<td>DY2 Q4</td>
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*New York State Department of Health*

**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**

**Advocate Community Providers, Inc. (PPS ID:25)**
reporting will be developed to track progress, including providing feedback that allow for process improvement, referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>Task 6 Implement pilot programs that target high-risk neighborhoods or areas with high concentrations of attributed patients. High-risk areas would focus on the conditions related to ACP's selected projects. Culturally competent Community Health Workers and other staff as well as Community Based Organization partners would work in tandem to ensure use of resources are efficient and effective. Pilot programs would include education, patient engagement and navigation of healthcare delivery system.</td>
<td>Project</td>
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<tr>
<td>Task 7 Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and deploy resources to target areas.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>06/30/2017</td>
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<td>DY3 Q1</td>
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<td>Task 8 Develop tool to track activities and establish key performance indicators and success metrics that tie to overall goals of the projects.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
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<th>DY2,Q4</th>
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<tr>
<td>Milestone #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.</td>
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<td>Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.</td>
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<td>Task 1 Develop participation agreement language for each provider type requiring mandatory participation in the ACP Integrated Delivery System. Assess feasibility of developing borough-level organization regarding communication and large-scale implementation, such as integrated delivery system or the population health projects. ACP PPS is community-based and community-physician led. A majority of our community partners have been included because the Medicaid patients assigned to</td>
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<td>our physicians use the physicians within the network. Thus, these providers have been included in large scale within ACP’s network and will continue to assist the providers and the patients in providing appropriate medical care and social support. Additionally, most community-based provider types (including Mental Health, Substance Abuse and Social Supports) will be included in the PPS network.</td>
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<td>2 Establish a Project 2.a.i. Leadership Team with roles and responsibilities to take a leadership role on this project. Project will be co-led by the Director of Clinical Operations, Lidia Virgil and Director of IT, John Dionisio. Team will include expertise from all areas (IT and IT security, Clinical Operations, Workforce [Moises Perez], Compliance [Tom Hoering], amongst others) and will require support from providers and staff. Additionally, because of the heavy dependencies on IT, support from physician EHR vendors will also be key in the success of the creation of an integrated delivery system.</td>
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<td>3 Develop Project 2.a.i. Roadmap with timeline which would include flexibility to be reviewed and updated at least annually and ability to explore adding potential partners (including social service organizations/CBOs). The roadmap will incorporate any IT assessments derived from the IT milestones, determine future state and propose solutions to achieve the target state. The roadmap will consider the connectivity needs of all provider types (including Mental Health, Substance Abuse and Social Supports) to create an integrated solution.</td>
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<td>4 Finalize (including ACP Board approval) Project 2.a.i. Roadmap with timeline, including timeline for provider contracting with partners within the organization.</td>
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<td>Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS’ strategy towards evolving into an IDS.</td>
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<td>PPS produces a list of participating HHs and ACOs.</td>
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<td>Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.</td>
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<td>Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.</td>
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NYS Confidentiality – High
## Project Requirements

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<td>Identify key Health Homes and ACO partners to create workgroup (include discussions with relevant committees, for example, IT Committee on integrating IT capabilities)</td>
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<td>Develop matrix of core capabilities of partnering Health Homes and ACOs, including provider services, IT assessments, etc. Matrix, as part of roadmap, should identify strengths and weaknesses of existing systems and processes. IT integration solution shall incorporate existing system strengths (strong network, structured communication processes, referral tracking, care management capabilities, strategies regarding patient compliance) and complement weaknesses (manual workarounds, workflow gaps, resource gaps, IT shortfalls).</td>
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<td>Develop strategy for partnering with Health Home and ACO population management systems and capabilities that incorporates roadmap and matrix developments. Leverage existing effective processes and understand components that are needed to scale processes to broader network. Introduce centralized processes that the PPS will manage to assist with expanding scale.</td>
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<td>Finalize strategy and incorporate into Project 2.a.i Roadmap with timeline, with flexibility to be reviewed and updated at least annually. Flexibility of design will allow for continuous system improvement that will maximize impact within network.</td>
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<td>Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.</td>
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<td>Clinically Interoperable System is in place for all participating providers.</td>
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<td>PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.</td>
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<td>PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.</td>
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<td>PPS trains staff on IDS protocols and processes.</td>
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**NYS Confidentiality – High**
### Project Requirements (Milestone/Task Name)

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<tbody>
<tr>
<td>1 ACP needs to understand the population it serves in order to ensure appropriate care is provided. Categorize ACP attributed beneficiaries into stratified risk groups using a common model (e.g., HCC, John Hopkins, 3M) and identify priority disease conditions for each category (based on State provided data on ACP's attributed beneficiaries, claims data from MAPP, Salient, IPAs’/ACOs’ data from MCOs and Medicare, and providers’ EHRs/medical record data). The data can come from variety of sources, including State, MCO and physician EHR. Stratification then allows PPS to understand and develop specific interventions that can positively impact patients (High-risk patients will require extensive, coordinated care. Moderate-risk patients will require some care, but as important, should received proper care that keeps the patient at moderate-risk status or potentially drop to low-risk status if possible [goal is to prevent patient from entering high-risk status]. Low-risk patients will need to receive preventive care to ensure that this cohort remain low-risk and does not move up to moderate or high-risk status.). Stratification algorithm based on common models can be developed/formalized in concert with PPS analytics team that is being assembled.</td>
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<td>2 Review and adopt clinical protocols from PPS's selected Domain 2,3 and 4 projects for priority disease conditions among ACP attributed members. Protocols outline care steps that will guide physicians to ensure appropriate health care is provided. If required, appropriate community and social supports will be included in care plans to ensure member receives holistic (or whole-person) care. ACP's leadership and network safety-net community partners understands the population that it serves often require more than medical care. Supports from CBOs, Mental Health/Substance Abuse organizations, post-acute care such as Skilled Nursing Facilities and some Nursing Homes, long-term care providers and public health services are key to ensuring care is provided and maintained in between physician visits.</td>
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<td>3 Develop a directory of available resources (includes typical and atypical providers types). Typical providers types are those who provide medical care such as physicians, clinics, hospitals, behavioral health, substance abuse, etc. Atypical providers are those who address socio-economic factors such as housing agencies, community-based organizations and social services. These resources can provide services based on the clinical</td>
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<tr>
<td>4 Identify additional provider type gaps based on resource directory and take necessary action to fill those gaps looking at all provider types, such as reaching out to CBOs and providers for participation in ACP. Network will continue to evolve as ACP's members' needs change. It is important to ensure patients needs are continually monitored to ensure appropriate care is given. Stratification step (step 1) will be completed periodically to ensure that the appropriate provider types are available.</td>
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<td>5 Develop system to engage patients with PPS using variety of methods such as patient navigators, community health workers, or access to patient portals that allow for a systematic way of communication between PPS, its partners and the patient requiring care. Currently, many agencies conduct patient outreach, however there is opportunity to improve patient engagement. ACP will assess creative yet practical ways to engage with patients including electronic outreach (smart phone apps, telephonic/text reminders) and community-based outreach (outreach to caregivers). PPS will also utilize patient satisfaction survey tools to assess ways to improve patient satisfaction (high levels of patient satisfaction has shown high levels of compliance) to improve patient compliance.</td>
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<td>6 Finalize ACP care coordination strategy to include structure, roles, responsibilities, services, policies and procedures, with linkages to other work streams as detailed in the ACP projects implementation plan. ACP plans to centralize its care coordination function (while leveraging existing effective care coordination processes within its network) where referral management and patient engagement strategies are key roles. Care coordination is a core function within an integrated delivery system - sufficient resources, tools and support, workflows and strategies will be included in the final roadmap. Support from other workstreams such as IT (ensure technology enables communication and the coordination), clinical operations (ensure protocols provide appropriate evidence-based care pathways for physicians to follow), workforce (appropriate training and re-training is provided so that the process is followed), and practitioner engagement (ensure physicians understand their roles with the provision of care) will assist with effective care coordination.</td>
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**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**

**Advocate Community Providers, Inc. (PPS ID: 25)**

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<tbody>
<tr>
<td><strong>Task</strong> 7 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely to patients. Processes will be developed to track progress, including providing feedback that allow for process improvement. Metrics to assist with measuring timely delivery of services include: Referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.</td>
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<td><strong>Task</strong> 8 Begin implementation of ACP projects implementation plan which includes tracking that patients receive appropriate support and care. This can be performed in various ways, such as understanding care gaps and outreaching to patients to close. PCMH, a major component of this project, specifically outlines various clinical care process improvement requirements involving immunization, preventive care and chronic or acute care measures.</td>
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<td><strong>Milestone #4</strong> 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.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
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<td><strong>Task</strong> PPS uses alerts and secure messaging functionality.</td>
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<td><strong>Task</strong> 1 Establish work plans with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to</td>
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## Project Requirements (Milestone/Task Name)

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<th>DY2,Q4</th>
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<tr>
<td>share information among PPS safety net partners who use eClinical Works EHR.</td>
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<td><strong>Task 2</strong> Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feed into HIE.</td>
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<td><strong>Task 3</strong> Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.</td>
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<td><strong>Task 4</strong> Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.</td>
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<td><strong>Task 5</strong> Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.</td>
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<td><strong>Task 6</strong> Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.</td>
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<td><strong>Task 7</strong> Develop final plan for sharing health information among clinical partners by DY3.</td>
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<td><strong>Task 8</strong> Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.</td>
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### Milestone #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.

**Task**

- EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).  

**Task**

- PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.

**Task**

- Survey and group all participating safety net providers into level of readiness.
## Project Requirements

### Task
1. Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based on the different levels (e.g., those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).

### Task
2. Establish communications/marketing plan and outreach to all ACP safety net providers that also identifies support resources.

### Task
3. Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.

### Milestone #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.

### Task
1. Refine priority of clinical issues from CNAs to include specific priorities by geographic areas and ensure alignment between projects undertaken.

### Task
2. Create a database for program planning (expand on data collected as part of our CNA).

### Task
3. Review adopted clinical protocols, care guidelines, established performance measures and metrics for each clinical area with participating safety net providers to monitor progress in managing population health.

### Task
4. Develop a population health database that is able to drill down at all levels using data from various sources, such as EHRs (with bi-directionally capable HIE).

### Task
5. Perform data analyses to identify priority clinical issues and establish registries.

### Task
6. Develop process to access individual provider EHRs and use registries to understand disease-specific drivers that will lead to...
### Project Requirements (Milestone/Task Name)

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<th>DY2,Q4</th>
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<th>DY3,Q2</th>
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<tbody>
<tr>
<td>Complete workforce assessment for care management capabilities among all participating safety net providers, including staff skills and resources required to manage priority at risk populations in each geographic area.</td>
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<td>Develop workforce training / re-training / support staff assignment to mitigate workforce gaps.</td>
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<td>Deploy staff support at provider level to train providers and staff on how to use and apply information learned from registries; how to establish care guidelines, develop disease pathways and inform on metrics for monitoring progress in managing population health.</td>
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<td>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.</td>
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<td>Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.</td>
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<td>All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.</td>
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<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.).</td>
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<td>Survey and group all participating providers (safety net and non safety net) into level of readiness.</td>
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<td>Develop plan, timelines, and assign resources for each level of readiness.</td>
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<td>Clinical governance committee approves partner assessment results and PCMH roadmap.</td>
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<td>Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).</td>
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**NYS Confidentiality – High**
## Project Requirements (Milestone/Task Name)

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<tr>
<td>5 Implement plan.</td>
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<td>6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.</td>
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<td><strong>Milestone #8</strong></td>
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<td><strong>Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.</strong></td>
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<td><strong>Medicaid Managed Care contract(s) are in place that include value-based payments.</strong></td>
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<tr>
<td>1 Complete value-based payment arrangement assessment at each IPA (each IPAs to review its respective list of existing contracts with MCOs and other payers and identify and explore opportunities for value-based payment arrangements). Leverage activities from Financial Sustainability workstream regarding contracting with MCOs regarding VBP. Lastly, assessment results will determine best options to take for establishing VBP contracts.</td>
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<td>2 Establish ACP Financial Sustainability/VBP committee to explore ACP contracts with MCOs and other payers on value-based payment arrangements.</td>
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<td>3 Develop ACP value-based payment roadmap. Roadmap, similar to New York State Roadmap for Medicaid Payment Reform (‘A Path toward Value Based Payment’), cohorts need to be established to understand which methodologies will be the most appropriate. All Care for Total Population Option may not be the optimal option initially, especially for high risk subpopulations or populations where bundling might be a better option; however it is expected to achieve level 3 VBP regardless VBP type. Currently, the IPAs are under a capitated/FFS with risk sharing (All Care for Total Population Level 2). The IPAs are familiar with this concept and with appropriate reporting (to emphasize focus on outcomes) and support, the groups can effectively transition into Level 3. For other providers, the other VBP options will be discussed directly and recommendations presented as to how each provider type (BH, SUD, SNF, Hospital, Health Home, CBOs, etc) will be compensated.</td>
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<td>4 Approve ACP value-based payment roadmap.</td>
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<td>Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.</td>
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<td>PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.</td>
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<td>1 Identify MCOs.</td>
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<td>2 Establish committee.</td>
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<td>3 Develop committee charter, goals, meeting schedules, etc.</td>
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<td>4 Conduct monthly meeting with MCOs to discuss utilization trends, performance issues, and payment reform issues.</td>
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<td>5 Initiate VBP transition plan including interim steps and complete by DSRIP timelines.</td>
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<td>Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.</td>
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<td>PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation</td>
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<td>Providers receive incentive-based compensation consistent with DSRIP goals and objectives.</td>
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<tr>
<td>1 Establish committee (committee will include expertise from other workstreams such as Clinical Programs (Lidia Virgil), Compliance (Tom Hoering), Finance (Wallace Lau), IT (John Dionisio). The IPA leadership (Ramon Tallaj, MD, Henry Chen, MD, Emilio Villegas, MD) will play a role with physician engagement. Other providers such as hospitals (NSLIJ and Medisys Hospital System) will also represent. The PAC will also be engaged as they represent the overall network (including post-acute care providers, CBOs, BH and SUD, etc). Lastly, the MCOs will need to be part of this committee or play an advisory role to ensure the VBP levels and options are operationally feasible and to establish appropriate timelines based on DSRIP commitments.</td>
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<td>2 Develop committee charter, goals, meeting schedules, work plan, deliverables and timelines.</td>
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<tr>
<td>Task 3 Approve a roadmap for transition towards value-based payment by aligning provider compensation to patient outcomes. Performance reporting is a major component to VBP. MCOs will need to provide adequate data and reporting to tie practitioner performance to patient outcomes.</td>
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<td>Task 4 Conduct meeting(s) with safety net providers to obtain comments, ideas, suggestions, obstacles, issues, possible solutions. VBP approach is key with a large network with a wide spectrum of provider types. MCO contracting will need to ensure VBP approach is appropriate.</td>
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<td>Task 5 Conduct meeting(s) with MCOs to ensure needs are addressed, such as appropriate contracting language, data exchange and benchmark info that will determine goals.</td>
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<td>Task 6 Develop potential models that adhere to roadmap guidelines that are appropriate to cost categories (total population care vs sub-population care vs bundling, etc). The various physician groups within ACP has familiarity with risk contracting and capitation models that could help facilitate the transition to VBP.</td>
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<td>Task 7 Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and finalize contracting points and terms with MCOs.</td>
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<td>Task 8 Implement plan and establish monthly/quarterly meetings to ensure VBP models are successful and understand the drivers of success. If VBP models are unsuccessful, develop targeted initiatives that impact cost drivers, taking both unit cost and utilization metrics of the various cost categories into consideration.</td>
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<td>Milestone #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 appropriate.</td>
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<td>Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.</td>
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<td>Task 1 Establish patient engagement committee.</td>
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<td>Task 2 Establish committee charter, work plan, milestones, timelines.</td>
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NYS Confidentiality – High
### Project Requirements

#### (Milestone/Task Name)

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<td>3</td>
<td>Develop an IDS patient engagement plan that is culturally appropriate. Plan should also include assessment of health literacy of patients so initiatives can be developed to address potential health literacy barriers. Socio-economic factors should be considered so that medical needs become a priority for patients. Use of community health workers, peers, advocacy groups, families and caregivers can supplement traditional outreach methods (such as mailers or telephonic outreach). These groups are typically from the same community, culturally competent and can be trained to have high levels or health literacy to convey messages effectively. In addition, community-based organizations have grassroots level reach to members and can assist with engagement with the providers within the PPS. Lastly, plan should include assessment of patient satisfaction. As previously mentioned, high levels of patient satisfaction can lead to higher levels of patient engagement.</td>
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<td>4</td>
<td>Develop potential models and design, including development of workforce requirements, such as training or re-training community health workers, peers, advocacy groups and CBOs. Because ACP is a physician-led, community-based PPS, it has wide array of provider types that it can leverage to engage patients in very culturally appropriate ways. Aligning these resources will assist with effective outreach and patient engagement.</td>
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<td>Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely and patients remain engaged. Processes and reporting will be developed to track progress, including providing feedback that allow for process improvement. Referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.</td>
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<td>Implement pilot programs that target high-risk neighborhoods or areas with high concentrations of attributed patients. High-risk areas would focus on the conditions related to ACP’s selected projects. Culturally competent Community Health Workers and other staff as well as Community Based Organization partners would work in tandem to ensure use of resources are efficient and effective. Pilot programs would include education, patient engagement and navigation of</td>
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<td>healthcare delivery system.</td>
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<td><strong>Task</strong> 7 Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and deploy resources to target areas.</td>
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<td><strong>Task</strong> 8 Develop tool to track activities and establish key performance indicators and success metrics that tie to overall goals of the projects.</td>
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### Milestone #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.

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<tr>
<td><strong>Task</strong> PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.</td>
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<td><strong>Task</strong> 1 Develop participation agreement language for each provider type requiring mandatory participation in the ACP Integrated Delivery System. Assess feasibility of developing borough-level organization regarding communication and large-scale implementation, such as integrated delivery system or the population health projects. ACP PPS is community-based and community-physician led. A majority of our community partners have been included because the Medicaid patients assigned to our physicians use the physicians within the network. Thus, these providers have been included in large scale within ACP's network and will continue to assist the providers and the patients in providing appropriate medical care and social support. Additionally, most community-based provider types (including Mental Health, Substance Abuse and Social Supports) will be included in the PPS network.</td>
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<td><strong>Task</strong> 2 Establish a Project 2.a.i. Leadership Team with roles and responsibilities to take a leadership role on this project. Project will be co-led by the Director of Clinical Operations, Lidia Virgil and Director of IT, John Dionisio. Team will include expertise</td>
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NYS Confidentiality – High
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- **from all areas (IT and IT security, Clinical Operations, Workforce [Moises Perez], Compliance [Tom Hoering], amongst others) and will require support from providers and staff. Additionally, because of the heavy dependencies on IT, support from physician EHR vendors will also be key in the success of the creation of an integrated delivery system.**

- **Task 3 Develop Project 2.a.i. Roadmap with timeline which would include flexibility to be reviewed and updated at least annually and ability to explore adding potential partners (including social service organizations/CBOs). The roadmap will incorporate any IT assessments derived from the IT milestones, determine future state and propose solutions to achieve the target state. The roadmap will consider the connectivity needs of all provider types (including Mental Health, Substance Abuse and Social Supports) to create an integrated solution.**

- **Task 4 Finalize (including ACP Board approval) Project 2.a.i. Roadmap with timeline, including timeline for provider contracting with partners within the organization.**

- **Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS’ strategy towards evolving into an IDS.**

- **Task PPS produces a list of participating HHs and ACOs.**

- **Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.**

- **Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.**

- **Task 1 Identify key Health Homes and ACO partners to create workgroup (include discussions with relevant committees, for example, IT Committee on integrating IT capabilities)**

- **Task 2. Develop matrix of core capabilities of partnering Health Homes and ACOs, including provider services, IT assessments, etc. Matrix, as part of roadmap, should identify strengths and weaknesses of existing systems and processes. IT integration solution shall incorporate existing system strengths (strong network, structured communication processes, referral tracking, care management capabilities, strategies regarding patient...**
### Project Requirements

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<td>compliance) and complement weaknesses (manual workarounds, workflow gaps, resource gaps, IT shortfalls).</td>
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<td>Task 3. Develop strategy for partnering with Health Home and ACO population management systems and capabilities that incorporates roadmap and matrix developments. Leverage existing effective processes and understand components that are needed to scale processes to broader network. Introduce centralized processes that the PPS will manage to assist with expanding scale.</td>
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<td>Task 4 Finalize strategy and incorporate into Project 2.a.i Roadmap with timeline, with flexibility to be reviewed and updated at least annually. Flexibility of design will allow for continuous system improvement that will maximize impact within network.</td>
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<td>Milestone #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.</td>
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<td>Task Clinically Interoperable System is in place for all participating providers.</td>
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<td>Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.</td>
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<td>Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.</td>
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<td>Task PPS trains staff on IDS protocols and processes.</td>
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<td>Task 1 ACP needs to understand the population it serves in order to ensure appropriate care is provided. Categorize ACP attributed beneficiaries into stratified risk groups using a common model (e.g., HCC, John Hopkins, 3M) and identify priority disease conditions for each category (based on State provided data on ACP's attributed beneficiaries, claims data from MAPP, Salient, IPAs' / ACOs' data from MCOs and Medicare, and providers' EHRs / medical record data). The data can come from variety of sources, including State, MCO and physician EHR. Stratification then allows PPS to understand and develop specific interventions that can positively impact patients (High-risk patients will require extensive, coordinated care.</td>
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### Project Requirements

**Task 2**: Review and adopt clinical protocols from PPS's selected Domain 2,3 and 4 projects for priority disease conditions among ACP attributed members. Protocols outline care steps that will guide physicians to ensure appropriate health care is provided. If required, appropriate community and social supports will be included in care plans to ensure member receives holistic (or whole-person) care. ACP's leadership and network safety-net community partners understands the population that it serves often require more than medical care. Supports from CBOs, Mental Health/Substance Abuse organizations, post-acute care such as Skilled Nursing Facilities and some Nursing Homes, long-term care providers and public health services are key to ensuring care is provided and maintained in between physician visits.

**Task 3**: Develop a directory of available resources (includes typical and atypical providers types). Typical providers types are those who provide medical care such as physicians, clinics, hospitals, behavioral health, substance abuse, etc. Atypical providers are those who address socio-economic factors such as housing agencies, community-based organizations and social services. These resources can provide services based on the clinical protocols for care coordination needs and address gaps that are delivered in appropriate settings.

**Task 4**: Identify additional provider type gaps based on resource directory and take necessary action to fill those gaps looking at all provider types, such as reaching out to CBOs and providers for participation in ACP. Network will continue to evolve as ACP's members’ needs change. It is important to ensure patients needs are continually monitored to ensure appropriate care is given. Stratification step (step 1) will be completed periodically to ensure that the appropriate provider types are available.

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<td>Moderate-risk patients will require some care, but as important, should received proper care that keeps the patient at moderate-risk status or potentially drop to low-risk status if possible [goal is to prevent patient from entering high-risk status]. Low-risk patients will need to receive preventive care to ensure that this cohort remain low-risk and does not move up to moderate or high-risk status.). Stratification algorithm based on common models can be developed/formalized in concert with PPS analytics team that is being assembled.</td>
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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name)

| Task | 5 Develop system to engage patients with PPS using variety of methods such as patient navigators, community health workers, or access to patient portals that allow for a systematic way of communication between PPS, its partners and the patient requiring care. Currently, many agencies conduct patient outreach, however there is opportunity to improve patient engagement. ACP will assess creative yet practical ways to engage with patients including electronic outreach (smart phone apps, telephonic/text reminders) and community-based outreach (outreach to caregivers). PPS will also utilize patient satisfaction survey tools to assess ways to improve patient satisfaction (high levels of patient satisfaction has shown high levels of compliance) to improve patient compliance. |
| Task | 6 Finalize ACP care coordination strategy to include structure, roles, responsibilities, services, policies and procedures, with linkages to other work streams as detailed in the ACP projects implementation plan. ACP plans to centralize its care coordination function (while leveraging existing effective care coordination processes within its network) where referral management and patient engagement strategies are key roles. Care coordination is a core function within an integrated delivery system - sufficient resources, tools and support, workflows and strategies will be included in the final roadmap. Support from other workstreams such as IT (ensure technology enables communication and the coordination), clinical operations (ensure protocols provide appropriate evidence-based care pathways for physicians to follow), workforce (appropriate training and re-training is provided so that the process is followed), and practitioner engagement (ensure physicians understand their roles with the provision of care) will assist with effective care coordination. |
| Task | 7 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely to patients. Processes will be developed to track progress, including providing feedback that allow for process improvement. Metrics to assist with measuring timely delivery of services include: Referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc. |
| Task | 8 Begin implementation of ACP projects implementation plan which includes tracking that patients receive appropriate support and care. This can be performed in various ways, such |

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### NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

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<tr>
<th>Milestone/Task Name</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
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<tr>
<td>as understanding care gaps and outreaching to patients to close. PCMH, a major component of this project, specifically outlines various clinical care process improvement requirements involving immunization, preventive care and chronic or acute care measures.</td>
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<tr>
<td>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.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td><strong>Task</strong> PPS uses alerts and secure messaging functionality.</td>
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<td><strong>Task</strong> 1 Establish work plans with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR.</td>
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<td><strong>Task</strong> 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feed into HIE.</td>
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<tr>
<td><strong>Task</strong> 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.</td>
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<td><strong>Task</strong> 4 Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or</td>
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### Project Requirements

**Milestone/Task Name**

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<tr>
<th>Task</th>
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<tbody>
<tr>
<td>5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.</td>
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<tr>
<td>6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.</td>
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<tr>
<td>7 Develop final plan for sharing health information among clinical partners by DY3.</td>
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<tr>
<td>8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.</td>
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</table>

**Milestone #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.

**Task**

| EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). |
| PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM. |

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<tr>
<th>Task</th>
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<tbody>
<tr>
<td>1 Survey and group all participating safety net providers into level of readiness.</td>
</tr>
<tr>
<td>2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).</td>
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<tr>
<td>3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.</td>
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<tr>
<td>4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation</td>
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NYS Confidentiality – High
## Project Requirements

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<td>plan includes support from resources including PCMH CCEs. Support may include internal or external resources.</td>
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<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
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<td>PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.</td>
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<tr>
<td>1 Refine priority of clinical issues from CNAs to include specific priorities by geographic areas and ensure alignment between projects undertaken.</td>
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<td>2 Create a database for program planning (expand on data collected as part of our CNA)</td>
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<td>3 Review adopted clinical protocols, care guidelines, established performance measures and metrics for each clinical area with participating safety net providers to monitor progress in managing population health.</td>
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<td>4 Develop a population health database that is able to drill down at all levels using data from various sources, such as EHRs (with bi-directionally capable HIE)</td>
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<td>5 Perform data analyses to identify priority clinical issues and establish registries.</td>
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<td>6 Develop process to access individual provider EHRs and use registries to understand disease-specific drivers that will lead to population health initiatives.</td>
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<td>7 Complete workforce assessment for care management capabilities among all participating safety net providers, including staff skills and resources required to manage priority at risk populations in each geographic area.</td>
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<td>8 Develop workforce training / re-training / support staff assignment to mitigate workforce gaps.</td>
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<td>9 Deploy staff support at provider level to train providers and staff on how to use and apply information learned from registries; how to establish care guidelines, develop disease</td>
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NYS Confidentiality – High
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

Advocate Community Providers, Inc.  (PPS ID:25)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
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<tbody>
<tr>
<td>pathways and inform on metrics for monitoring progress in managing population health.</td>
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<td><strong>Milestone #7</strong></td>
<td>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.</td>
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<td><strong>Task</strong></td>
<td>Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.</td>
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<tr>
<td><strong>Task</strong></td>
<td>All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.</td>
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<tr>
<td><strong>Task</strong></td>
<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)</td>
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<tr>
<td><strong>Task</strong></td>
<td>1 Survey and group all participating providers (safety net and non safety net) into level of readiness.</td>
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<td><strong>Task</strong></td>
<td>2 Develop plan, timelines, and assign resources for each level of readiness.</td>
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<td><strong>Task</strong></td>
<td>3 Clinical governance committee approves partner assessment results and PCMH roadmap.</td>
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<td><strong>Task</strong></td>
<td>4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).</td>
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<td><strong>Task</strong></td>
<td>5 Implement plan.</td>
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<td><strong>Task</strong></td>
<td>6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.</td>
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<td><strong>Milestone #8</strong></td>
<td>Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.</td>
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<td><strong>Task</strong></td>
<td>Medicaid Managed Care contract(s) are in place that include value-based payments.</td>
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<tr>
<td><strong>Task</strong></td>
<td>1 Complete value-based payment arrangement assessment at</td>
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Project Requirements

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<td>each IPA (each IPAs to review its respective list of existing contracts with MCOs and other payers and identify and explore opportunities for value-based payment arrangements). Leverage activities from Financial Sustainability workstream regarding contracting with MCOs regarding VBP. Lastly, assessment results will determine best options to take for establishing VBP contracts.</td>
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<td>Task 2</td>
<td>Establish ACP Financial Sustainability/VBP committee to explore ACP contracts with MCOs and other payers on value-based payment arrangements.</td>
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<tr>
<td>Task 3</td>
<td>Develop ACP value-based payment roadmap. Roadmap, similar to New York State Roadmap for Medicaid Payment Reform (‘A Path toward Value Based Payment’), cohorts need to be established to understand which methodologies will be the most appropriate. All Care for Total Population Option may not be the optimal option initially, especially for high risk subpopulations or populations where bundling might be a better option, however it is expected to achieve level 3 VBP regardless VBP type. Currently, the IPAs are under a capitated/FFS with risk sharing (All Care for Total Population Level 2). The IPAs are familiar with this concept and with appropriate reporting (to emphasize focus on outcomes) and support, the groups can effectively transition into Level 3. For other providers, the other VBP options will be discussed directly and recommendations presented as to how each provider type (BH, SUD, SNF, Hospital, Health Home, CBOs, etc) will be compensated.</td>
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<td>Task 4</td>
<td>Approve ACP value-based payment roadmap.</td>
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</tr>
</tbody>
</table>

Milestone 9

Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.

Task

PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.

Task 1 | Identify MCOs. |        |        |        |        |        |        |        |        |        |        |
| Task 2 | Establish committee. |        |        |        |        |        |        |        |        |        |        |
| Task 3 | Develop committee charter, goals, meeting schedules, etc. |        |        |        |        |        |        |        |        |        |        |
### Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Task Code</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 1</td>
<td>Establish committee (committee will include expertise from other workstreams such as Clinical Programs (Lidia Virgil), Compliance (Tom Hoering), Finance (Wallace Lau), IT (John Dionisio). The IPA leadership (Ramon Tallaj, MD, Henry Chen, MD, Emilio Villegas, MD) will play a role with physician engagement. Other providers such as hospitals (NSLU and Medisys Hospital System) will also represent. The PAC will also be engaged as they represent the overall network (including post-acute care providers, CBOs, BH and SUD, etc). Lastly, the MCOs will need to be part of this committee or play an advisory role to ensure the VBP levels and options are operationally feasible and to establish appropriate timelines based on DSRIP commitments.</td>
</tr>
<tr>
<td>Task 2</td>
<td>Develop committee charter, goals, meeting schedules, work plan, deliverables and timelines.</td>
</tr>
<tr>
<td>Task 3</td>
<td>Approve a roadmap for transition towards value-based payment by aligning provider compensation to patient outcomes. Performance reporting is a major component to VBP. MCOs will need to provide adequate data and reporting to tie practitioner performance to patient outcomes.</td>
</tr>
<tr>
<td>Task 4</td>
<td>Conduct meeting(s) with safety net providers to obtain comments, ideas, suggestions, obstacles, issues, possible solutions. VBP approach is key with a large network with a wide spectrum of provider types. MCO contracting will need to ensure VBP approach is appropriate.</td>
</tr>
<tr>
<td>Task 5</td>
<td>Initiate VBP transition plan including interim steps and complete by DSRIP timelines.</td>
</tr>
<tr>
<td>Milestone #10</td>
<td>Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.</td>
</tr>
<tr>
<td>Task 6</td>
<td>PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation.</td>
</tr>
<tr>
<td>Task 7</td>
<td>Providers receive incentive-based compensation consistent with DSRIP goals and objectives.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Task Code</th>
<th>Task Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 8</td>
<td>Conduct monthly meeting with MCOs to discuss utilization trends, performance issues, and payment reform issues.</td>
</tr>
</tbody>
</table>

---

**New York State Department Of Health**

**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**

**Advocate Community Providers, Inc. (PPS ID:25)**

**NYS Confidentiality – High**
## Project Requirements

<table>
<thead>
<tr>
<th>Task</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Conduct meeting(s) with MCOs to ensure needs are addressed, such as appropriate contracting language, data exchange and benchmark info that will determine goals.</td>
<td></td>
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</tr>
<tr>
<td>6 Develop potential models that adhere to roadmap guidelines that are appropriate to cost categories (total population care vs sub-population care vs bundling, etc). The various physician groups within ACP has familiarity with risk contracting and capitation models that could help facilitate the transition to VBP.</td>
<td></td>
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</tr>
<tr>
<td>7 Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and finalize contracting points and terms with MCOs.</td>
<td></td>
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</tr>
<tr>
<td>8 Implement plan and establish monthly/quarterly meetings to ensure VBP models are successful and understand the drivers of success. If VBP models are unsuccessful, develop targeted initiatives that impact cost drivers, taking both unit cost and utilization metrics of the various cost categories into consideration.</td>
<td></td>
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</tbody>
</table>

### Milestone #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 appropriate.

**Task**

Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.

**Task**

1 Establish patient engagement committee.

**Task**

2 Establish committee charter, work plan, milestones, timelines.

**Task**

3 Develop an IDS patient engagement plan that is culturally appropriate. Plan should also include assessment of health literacy of patients so initiatives can be developed to address potential health literacy barriers. Socio-economic factors should be considered so that medical needs become a priority for patients. Use of community health workers, peers, advocacy groups, families and caregivers can supplement traditional outreach methods (such as mailers or telephonic outreach). These groups are typically from the same community, culturally competent and can be trained to have high levels or health literacy to convey messages effectively. In
<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
</table>

**Task 4** Develop potential models and design, including development of workforce requirements, such as training or re-training community health workers, peers, advocacy groups and CBOs. Because ACP is a physician-led, community-based PPS, it has wide array of provider types that it can leverage to engage patients in very culturally appropriate ways. Aligning these resources will assist with effective outreach and patient engagement.

**Task 5** Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely and patients remain engaged. Processes and reporting will be developed to track progress, including providing feedback that allow for process improvement, referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.

**Task 6** Implement pilot programs that target high-risk neighborhoods or areas with high concentrations of attributed patients. High-risk areas would focus on the conditions related to ACP's selected projects. Culturally competent Community Health Workers and other staff as well as Community Based Organization partners would work in tandem to ensure use of resources are efficient and effective. Pilot programs would include education, patient engagement and navigation of healthcare delivery system.

**Task 7** Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and deploy resources to target areas.

**Task 8** Develop tool to track activities and establish key performance indicators and success metrics that tie to overall goals of the projects.

addition, community-based organizations have grassroots level reach to members and can assist with engagement with the providers within the PPS. Lastly, plan should include assessment of patient satisfaction. As previously mentioned, high levels of patient satisfaction can lead to higher levels of patient engagement.
Prescribed Milestones Current File Uploads

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Description</th>
<th>User ID</th>
<th>File Name</th>
<th>Upload Date</th>
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</thead>
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</table>

Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS’ strategy towards evolving into an IDS.</td>
<td></td>
</tr>
<tr>
<td>Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>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.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
<td></td>
</tr>
</tbody>
</table>
### Milestone Name: 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.

**Narrative Text:** In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.

### Milestone Name: Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.

### Milestone Name: Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.

### Milestone Name: Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.

### Milestone Name: Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.
**IPQR Module 2.a.i.4 - PPS Defined Milestones**

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
</table>

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**PPS Defined Milestones Current File Uploads**

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<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
</table>

No Records Found

**PPS Defined Milestones Narrative Text**

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
</table>

No Records Found
IPQR Module 2.a.i.5 - IA Monitoring

Instructions:

Milestone 10: The IA recommends tasks 6, 7, and 8 be written so that they are less general in nature and as current steps identified could apply to any quality project. Be more specific to this particular project when details are known.

Milestone 11: The IA recommends tasks 6, 7, and 8 be written so that they are less general in nature and as current steps identified could apply to any quality project. Be more specific to this particular project when details are known.
Project 2.a.iii – Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services

☑ IPQR Module 2.a.iii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions:

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Major risks to this project revolve around patient compliance. Patient compliance with plan of care can be heavily compromised by the low health literacy rate of the population served by ACP. The majority of the patients served by the ACP providers are immigrants who either do not speak English or speak very little English. Many of these patients have a low educational level and their overall literacy rate is low. This issue creates a population who relies more on word of mouth than on written plans making it difficult to evaluate the patient's comprehension and follow through on the plan of care. ACP plans to mitigate this risk through its strength in having culturally aligned providers who are of the same community and speak the same language as the patients that it serves. ACP will provide to the patient pans of care in the language that they speak and moreover will have staff who are also of the same culture and language as the patients follow up with the patients to ensure their comprehension of the plan as well as compliance with it. ACP has also put together a team of community based providers that will provide outreach and follow up with the patient in the language and culture that the patient is comfortable with. These community based organizations include homecare, nursing, social work, and others.
### IPQR Module 2.a.iii.2 - Project Implementation Speed

**Instructions:**

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.

Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>902</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Non-PCP Practitioners</td>
<td>1,428</td>
<td>0</td>
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<tr>
<td>Clinics</td>
<td>43</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>9</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Behavioral Health</td>
<td>130</td>
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<tr>
<td>Substance Abuse</td>
<td>34</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Pharmacies</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>1,418</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Total Committed Providers</strong></td>
<td><strong>3,985</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
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<tr>
<td>Percent Committed Providers(%)</td>
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<td>0.00</td>
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</table>

**NYS Confidentiality – High**
In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
Instructions:

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application. Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Year, Quarter (DY1,Q1 - DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>30,763</td>
<td>38,454</td>
<td>46,145</td>
<td>61,527</td>
<td>76,909</td>
<td>115,364</td>
<td>153,818</td>
<td>29,610</td>
<td>84,599</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>0.00</td>
<td>20.00</td>
<td>25.00</td>
<td>30.00</td>
<td>40.00</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
<td>19.25</td>
<td>55.00</td>
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</table>

<table>
<thead>
<tr>
<th>Year, Quarter (DY3,Q3 - DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
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<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>119,209</td>
<td>153,818</td>
<td>29,610</td>
<td>84,599</td>
<td>119,201</td>
<td>153,818</td>
<td>29,610</td>
<td>84,599</td>
<td>119,201</td>
<td>153,818</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>77.50</td>
<td>100.00</td>
<td>19.25</td>
<td>55.00</td>
<td>77.49</td>
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<td>19.25</td>
<td>55.00</td>
<td>77.49</td>
<td>100.00</td>
</tr>
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</table>

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
### IPQR Module 2.a.iii.4 - Prescribed Milestones

**Instructions:**

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone #1: Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task: A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 1: Develop protocol for identification of Patients at risk for progressing to Health Home eligibility. Protocol shall contain definitions, and intervention through PCPs, Care Managers and Coordinators/Health Homes, and specialists</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 2: Develop a health home at risk intervention model with prescribed implementation of Comprehensive Care plans for each patient with a chronic progressive disease. Care plans will be uniform and distributed throughout the PPS provider partners through the provider engagement teams. Short cuts and in-putting and monitoring of these within provider EMRs will be developed and trained by the team.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 3: Disseminate protocol to ACP PCPs to treat patients in accordance with evidence based protocols to include referrals to specialist and social services as necessary.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 4: Develop Care Plan to include patient self-management techniques, disease specific education, how to recognize triggers, remove hazards and avoid complications.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 5: Ensure that Care Plans are created, printed and explained in the language of the patients being served and implemented in a culturally appropriate manner.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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</tr>
<tr>
<td>Task 6: Develop ACP processes and procedures included in protocols to include</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
</tbody>
</table>
more stringent care coordination emulating health homes at the Primary Care office with PCMH level standards of care.

**Task**
7 Creation of Central Care Management/Care coordination teams at the level of health Homes through ACP’s intense back office/Care Coordination department to provide more centralized, efficient integrated care.

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>more stringent care coordination emulating health homes at the Primary Care office with PCMH level standards of care.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
</tbody>
</table>

**Milestone #2**
Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.

**Task**
All practices meet NCQA 2014 Level 3 PCMH and APCM standards

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>All practices meet NCQA 2014 Level 3 PCMH and APCM standards</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
</tbody>
</table>

**Task**
Ensure that all participating 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.

**Task**
EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.
### Project Requirements

#### (Milestone/Task Name)

**EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.**

**Task**

- Provider
  - Safety Net Health Home / Care Management
  - In Progress
  - Start Date: 07/01/2015
  - End Date: 03/31/2018
  - Quarter: DY3 Q4

**Task**

- Provider
  - In Progress
  - Start Date: 07/01/2015
  - End Date: 03/31/2018
  - Quarter: DY3 Q4

**Task**

- Project
  - Safety Net Health Home / Care Management
  - In Progress
  - Start Date: 10/01/2015
  - End Date: 09/30/2016
  - Quarter: DY2 Q2

**Task**

- Project
  - In Progress
  - Start Date: 10/01/2015
  - End Date: 03/31/2017
  - Quarter: DY2 Q4

**Task**

- Project
  - In Progress
  - Start Date: 01/01/2016
  - End Date: 03/31/2017
  - Quarter: DY2 Q4

**Task**

- Project
  - In Progress
  - Start Date: 04/01/2015
  - End Date: 12/31/2015
  - Quarter: DY1 Q3

**Task**

- Project
  - In Progress
  - Start Date: 07/01/2016
  - End Date: 03/31/2018
  - Quarter: DY3 Q4

**Task**

- Project
  - In Progress
  - Start Date: 07/01/2016
  - End Date: 03/31/2018
  - Quarter: DY3 Q4

**Task**

- Project
  - In Progress
  - Start Date: 07/01/2016
  - End Date: 03/31/2018
  - Quarter: DY3 Q4

**Task**

- Project
  - In Progress
  - Start Date: 07/01/2016
  - End Date: 03/31/2018
  - Quarter: DY3 Q4

**Task**

- Project
  - In Progress
  - Start Date: 10/01/2015
  - End Date: 12/31/2015
  - Quarter: DY1 Q3

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Health Home / Care Management</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>PPS uses alerts and secure messaging functionality.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>1 Work with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
</tr>
<tr>
<td>2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
<td></td>
</tr>
<tr>
<td>3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
<td></td>
</tr>
<tr>
<td>4 Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>7 Develop final plan for sharing health information among clinical partners by DY3.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>9 Develop tracking tool linked to physician database to understand physician data sharing activities on health information exchange/RHIO/SHIN-NY.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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</tbody>
</table>
### Project Requirements

<table>
<thead>
<tr>
<th>Task</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Periodically review physicians (more frequently at the beginning) to ensure data is being shared and that bi-directional activities are evident.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #4</strong> Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 1 Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 5 Develop tracking tool linked to physician database to monitor EHR system use. Additionally, physician process adherence will be tracked (methodologies should follow developed protocols and how-to’s).</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 6 Develop remediation plan with steps for assisting physicians that require additional support in appropriate use of EHR systems to support PCMH requirements.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #5</strong> Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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</tbody>
</table>

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Project Requirements
(Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
net providers. | Project | In Progress | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting. | Project | In Progress | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
Task 1 Develop and implement algorithm to be used to stratify and identify target patients. Algorithm to include specific chronic disease codes to understand at-risk population. | Project | In Progress | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
Task 2 Develop a strategy with timeline to be used to obtain significant data from EMR registries or from practice management systems. Data should include in all cases patient demographics in addition to the specified data used in the algorithm. | Project | In Progress | 10/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
Task 3 Identify data analytics staff or practice champion to perform the data pulls at the specified times. | Project | In Progress | 10/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
Task 4 Perform comparative analysis using data pulls from ACP central data repository and other platforms such as Salient and MCOs to validate and verify data and implement targeted and population health strategies. | Project | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors. | Project | N/A | In Progress | 07/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4
Task Procedures to engage at-risk patients with care management plan instituted. | Project | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
Task 1 Develop comprehensive care plans to distribute throughout the PPS with disease specific education and instruction on self-management, risk reduction, identification and elimination of triggers. The comprehensive care plans also include home assessments and family/caregiver intervention. The Care Plans will be presented to the patient with appropriate training at the point of care by the Primary Care Provider. | Project | In Progress | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4
Task 2 Create a back office protocol that consists of outreach staff, care coordinators that will remain in contact with the patients, establish a rapport with the patient and caregiver/family to ensure that communication gaps and patient discomfort levels are resolved. The number of calls and follow ups per week/month will vary depending on patient's health status and patient's health literacy rates. Care Coordinators will...
## Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Reporting Level</th>
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<th>End Date</th>
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<tbody>
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<td>DY1 Q4</td>
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<tr>
<td>Task 3</td>
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<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 3</td>
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<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
</tbody>
</table>

### Task 3 Hire and train Care Managers in the back office to also be readily available to the patients and reach out and be manage their care ie. Medications, counsel, etc. thus ensuring that the patient has what he/she needs for management of disease and increased quality of life.

### Milestone #7

Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.

### Task

Each identified PCP establish partnerships with the local Health Home for care management services.

### Task

Each identified PCP establish partnerships with the local Health Home for care management services.

### Task

1. Develop protocols in which each entity's roles are delineated. Protocol should clearly establish the primary care provider's responsibility, care plan implementation, as well as health home eligibility and the roles of the health home.

### Task

2. ACP will leverage its partner Health Homes and establish clear partnerships with the HH and PCPs through its regional Care Teams. ACP's care Teams are comprised of partners within a given region and they include providers of all types including HHs. Health Homes will be linked and partnered with the PCPs within their regions. The HHs and PCPs will collaborate in accordance with the set protocols and processes.

### Task

3. ACP has a vast number of patients, due to this, ACP will work with the HHs in the network to incorporate best practices and processes into a back office/care coordination team that will provide additional, enhanced care coordination and management.

### Task

4. Primary Care Provider's role shall be as per the protocol to provide evidence based disease management, implementing a comprehensive care plan for specific disease management. PCP office will work with Care Coordination.
**Project Requirements (Milestone/Task Name)** | **Reporting Level** | **Provider Type** | **Status** | **Start Date** | **End Date** | **Quarter End Date** | **DSRIP Reporting Year and Quarter**
---|---|---|---|---|---|---|---
Team in Health Home model care coordination | | | | | |
**Task**
5 Health Homes’ role shall be to provide guidance, assistance and support in the implementation of a Health Home model of Care Coordination as well as provide Health Home services as needed for patients eligible to receive care under the Medicaid Health Home eligibility criteria. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3

Milestone #6
Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).

**Task**
PPS has established partnerships to medical, behavioral health, and social services. | Project | N/A | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4

**Task**
PPS has established partnerships to medical, behavioral health, and social services. | Provider | Primary Care Physicians | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4

**Task**
PPS has established partnerships to medical, behavioral health, and social services. | Provider | Health Home / Care Management | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4

**Task**
PPS uses EHRs and HIE system to facilitate and document partnerships with needed services. | Project | | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4

**Task**
1 Establish relationships and partnership with Behavioral Health, OASAS, OMH entities and engage in a service agreement. Engage these entities in all regions and counties in which ACP serves. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4

**Task**
2 Establish relationships with local government, social and specialty services such as SPOAs, agencies for the developmentally disabled to coordinate and provide needed services to patients. | Project | | In Progress | 09/30/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4

**Task**
3 Include identified entities in Care Teams, PAC, Clinical Quality Committees to help develop, coordinate and disseminate best practices, protocols, etc and provide higher quality service. | Project | | In Progress | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2

**Task**
4 Liaise and form partnerships between these entities and the PCP especially in areas where these services have been lacking and patient are going without needed care and services. | Project | | In Progress | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4

**Task**
5 ACP will implement a referral process by which all referrals are entered and submitted via the EMR and go through an HIE. ACP partners’ and associated

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### Project Requirements

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
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<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>providers' information shall be uploaded and prompted to the PCP or other referrer as a referral database so that referrals can be made to the needed service provider or agency that has made a commitment to tend to ACP patients in the specified timeframe and manner.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 6 All referrals shall go through to the ACP central data repository and shall be stored and documented for monitoring and adherence to procedure.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 7 Referrals going through ACP’s HIE are picked up and are monitored by the ACP central care coordinators to ensure completeness and attainment of services in a timely and efficient manner and for further care coordination.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #9</strong> Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> PPS has included social services agencies in development of risk reduction and care practice guidelines.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 1 ACP will develop and implement best practices in care management and care coordination in conjunction with Health Home partners and develop evidence based protocols for disease management.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 2 Develop uniform Comprehensive Care plans which will include disease self management techniques and will also include risk reduction activities, recognizing of warning signs and family education and support materials. The Care plans will be in different languages to be given to the patient's of ACP in their appropriate language. Furthermore, the Care plans will be consistent with</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

Advocate Community Providers, Inc. (PPS ID:25)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
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<td>the Cultural sensitivities of the population/patient being served.</td>
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<tr>
<td>3 Develop Evidence based protocols for chronic diseases with the help of Primary care physicians, specialists physicians and associations such as JNC-8, American Lung Association, etc.</td>
<td>Project</td>
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<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
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<td>4 Disseminate protocols to all providers within the PPS through physician engagement meetings, physician engagement teams and IPAs.</td>
<td>Project</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
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<td>5 With the help of the IPAs, physician champions, the PAC, and other committees, obtain physician &quot;buy-in&quot; support and commitment on implementation of evidence based ACP protocols.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
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<td>6 Draft partner agreements sand obtain signatures from partners acknowledging participation and adherence to ACP protocols, processes and procedures.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
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<td>7 Establish partnerships and agreements with social services agencies to assist in the provision of needed services and implement risk reduction, +which can include protective services, shelter, housing, food, etc.</td>
<td>Project</td>
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<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
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<td>Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.</td>
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<td>A clear strategic plan is in place which includes, at a minimum:</td>
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<td>- Definition of the Health Home At-Risk Intervention Program</td>
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<td>- Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs</td>
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<tr>
<td>1 Develop protocol for identification of Patients at risk for progressing to Health Home eligibility. Protocol shall contain definitions, and intervention through PCPs, Care Managers and Coordinators/Health Homes, and specialists</td>
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<td>2 Develop a health home at risk intervention model with prescribed implementation of Comprehensive Care plans for each patient with a chronic progressive disease. Care plans will</td>
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NYS Confidentiality – High
## Project Requirements

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<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tr>
<td>be uniform and distributed throughout the PPS provider partners through the provider engagement teams. Short cuts and in-putting and monitoring of these within provider EMRs will be developed and trained by the team.</td>
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<td>Task 3 Disseminate protocol to ACP PCPs to treat patients in accordance with evidence based protocols to include referrals to specialist and social services as necessary.</td>
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<td>Task 4 Develop Care Plan to include patient self-management techniques, disease specific education, how to recognize triggers, remove hazards and avoid complications.</td>
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<td>Task 5 Ensure that Care Plans are created, printed and explained in the language of the patients being served and implemented in a culturally appropriate manner.</td>
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<td>Task 6 Develop ACP processes and procedures included in protocols to include more stringent care coordination emulating health homes at the Primary Care office with PCMH level standards of care.</td>
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<td>Task 7 Creation of Central Care Management/Care coordination teams at the level of health Homes through ACP's intense back office/Care Coordination department to provide more centralized, efficient integrated care.</td>
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### Milestone #2

Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.

#### Task

All practices meet NCQA 2014 Level 3 PCMH and APCM standards

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<thead>
<tr>
<th>DY1,Q1</th>
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</table>

#### Task

1. Leverage ACP's strong PCP network to establish and enhance relationships between partner hospitals and primary care providers for open communication and accessibility.

#### Task

2. Utilize physician engagement teams, IPA groups, and physician champions to engage all PCPs in ACP's network in the participation of DSRIP and educate on the importance of advanced primary care and achievement of NCQA 2014 PCMH certification.

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<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY1,Q1</th>
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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tbody>
<tr>
<td><strong>Task</strong> 3 Contract with PCMH certified professionals that will assist the practices in attaining 2014 NCQA PCMH accreditation by year 3.</td>
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<td><strong>Task</strong> 4 Develop tracking tool linked to physician database to understand progress for each physician undergoing PCMH certification.</td>
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<td><strong>Task</strong> 5 Develop remediation plan with steps for assisting physicians that require additional support in achieving 2014 PCMH level 3 accreditation.</td>
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<td><strong>Milestone #3</strong> Ensure that all participating 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.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td><strong>Task</strong> PPS uses alerts and secure messaging functionality.</td>
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<tr>
<td><strong>Task</strong> 1 Work with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.</td>
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<td><strong>Task</strong> 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.</td>
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<tr>
<td><strong>Task</strong> 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.</td>
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<td><strong>Task</strong> 4 Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and</td>
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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tr>
<td>patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.</td>
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<td><strong>Task 5</strong> Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.</td>
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<td><strong>Task 6</strong> Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.</td>
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<td><strong>Task 7</strong> Develop final plan for sharing health information among clinical partners by DY3.</td>
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<td><strong>Task 8</strong> Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.</td>
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<td><strong>Task 9</strong> Develop tracking tool linked to physician database to understand physician data sharing activities on health information exchange/RHIO/SHIN-NY.</td>
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<td><strong>Task 10</strong> Periodically review physicians (more frequently at the beginning) to ensure data is being shared and that bi-directional activities are evident.</td>
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#### Milestone #4

Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.

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<th>Task 1</th>
<th>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</th>
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<th>Task 2</th>
<th>PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</th>
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**Task 1** Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.

**Task 2** Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with
strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).

Task
3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.

Task
4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.

Task
5 Develop tracking tool linked to physician database to monitor EHR system use. Additionally, physician process adherence will be tracked (methodologies should follow developed protocols and how-to's).

Task
6 Develop remediation plan with steps for assisting physicians that require additional support in appropriate use of EHR systems to support PCMH requirements.

Milestone #5
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.

Task
PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.

Task
1 Develop and implement algorithm to be used to stratify and identify target patients. Algorithm to include specific chronic disease codes to understand at-risk population.

Task
2 Develop a strategy with timeline to be used to obtain significant data from EMR registries or from practice management systems. Data should include in all cases patient demographics in addition to the specified data used in the algorithm.

Task
3 Identify data analytics staff or practice champion to perform the data pulls at the specified times.

Task
4 Perform comparative analysis using data pulls from ACP central data repository and other platforms such as Salient and
Advocate Community Providers, Inc.  (PPS ID:25)

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<th>DY3,Q1</th>
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<tr>
<td>MCOs to validate and verify data and implement targeted and population health strategies.</td>
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<td>Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.</td>
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<td>Procedures to engage at-risk patients with care management plan instituted.</td>
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<td>1 Develop comprehensive care plans to distribute throughout the PPS with disease specific education and instruction on self-management, risk reduction, identification and elimination of triggers. The comprehensive care plans also include home assessments and family/caregiver intervention. The Care Plans will be presented to the patient with appropriate training at the point of care by the Primary Care Provider.</td>
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<td>2 Create a back office protocol that consists of outreach staff, care coordinators that will remain in contact with the patients, establish a rapport with the patient and caregiver/family to ensure that communication gaps and patient discomfort levels are resolved. The number of calls and follow ups per week/month will vary depending on patient's health status and patient's health literacy rates. Care Coordinators will ensure that appointments are made and kept, transportation is made available whenever necessary, orders are fulfilled and the patient receives any needed care.</td>
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<td>3 Hire and train Care Managers in the back office to also be readily available to the patients and reach out and be manage their care i.e. Medications, counsel, etc. thus ensuring that the patient has what he/she needs for management of disease and increased quality of life.</td>
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<td>Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.</td>
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<td>Each identified PCP establish partnerships with the local Health Home for care management services.</td>
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<td>Each identified PCP establish partnerships with the local Health</td>
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NYS Confidentiality – High
## Project Requirements

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<td>Home for care management services.</td>
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<td><strong>Task</strong> 1</td>
<td>Develop protocols in which each entity's roles are delineated. Protocol should clearly establish the primary care provider's responsibility, care plan implementation, as well as health home eligibility and the roles of the health home.</td>
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| **Task** 2 | Advocate Community Providers, Inc. (PPS ID:25)  

**Task 2**: ACP will leverage its partner Health Homes and establish clear partnerships with the HH and PCPs through its regional Care Teams. ACP's Care Teams are comprised of partners within a given region and they include providers of all types including HHs. Health Homes will be linked and partnered with the PCPs within their regions. The HHs and PCPs will collaborate in accordance with the set protocols and processes. |
| **Task** 3 | ACP has a vast number of patients, due to this, ACP will work with the HHs in the network to incorporate best practices and processes into a back office/care coordination team that will provide additional, enhanced care coordination and management. |
| **Task** 4 | Primary Care Provider’s role shall be as per the protocol to provide evidence based disease management, implementing a comprehensive care plan for specific disease management. PCP office will work with Care Coordination team in Health Home model care coordination. |
| **Task** 5 | Health Homes’ role shall be to provide guidance, assistance and support in the implementation of a Health Home model of Care Coordination as well as provide Health Home services as needed for patients eligible to receive care under the Medicaid Health Home eligibility criteria. |
| **Milestone #6** | Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments). |
| **Task** | Primary Care Providers (PCPs) have established partnerships with the Health Home. |
| **Task** | PPS has established partnerships to medical, behavioral health, and social services. |

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**NYS Confidentiality – High**
## Project Requirements

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- **Task**
  PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.

- **Task**
  1 Establish relationships and partnership with Behavioral Health, OASAS, OMH entities and engage in a service agreement. Engage these entities in all regions and counties in which ACP serves.

- **Task**
  2 Establish relationships with local government, social and specialty services such as SPOAs, agencies for the developmentally disabled to coordinate and provide needed services to patients.

- **Task**
  3 Include identified entities in Care Teams, PAC, Clinical Quality Committees to help develop, coordinate and disseminate best practices, protocols, etc and provide higher quality service.

- **Task**
  4 Liaise and form partnerships between these entities and the PCP especially in areas where these services have been lacking and patient are going without needed care and services.

- **Task**
  5 ACP will implement a referral process by which all referrals are entered and submitted via the EMR and go through an HIE. ACP partners' and associated providers’ information shall be uploaded and prompted to the PCP or other referrer as a referral database so that referrals can be made to the needed service provider or agency that has made a commitment to tend to ACP patients in the specified timeframe and manner.

- **Task**
  6 All referrals shall go through to the ACP central data repository and shall be stored and documented for monitoring and adherence to procedure.

- **Task**
  7 Referrals going through ACP’s HIE are picked up and are monitored by the ACP central care coordinators to ensure completeness and attainment of services in a timely and efficient manner and for further care coordination.

- **Milestone #9**
  Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.

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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name)

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<th>Task</th>
<th>DY1,Q1</th>
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<tr>
<td>PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.</td>
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<td>Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.</td>
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<tr>
<td>PPS has included social services agencies in development of risk reduction and care practice guidelines.</td>
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<td>Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.</td>
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<tr>
<td>1 ACP will develop and implement best practices in care management and care coordination in conjunction with Health Home partners and develop evidence based protocols for disease management.</td>
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<tr>
<td>2 Develop uniform Comprehensive Care plans which will include disease self management techniques and will also include risk reduction activities, recognizing of warning signs and family education and support materials. The Care plans will be in different languages to be given to the patient's of ACP in their appropriate language. Furthermore, the Care plans will be consistent with the Cultural sensitivities of the population/patient being served.</td>
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<td>3 Develop Evidence based protocols for chronic diseases with the help of Primary care physicians, specialists physicians and associations such as JNC-8, American Lung Association, etc.</td>
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<td>4 Disseminate protocols to all providers within the PPS through physician engagement meetings, physician engagement teams and IPAs.</td>
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<td>5 With the help of the IPAs, physician champions, the PAC, and other committees, obtain physician &quot;buy-in&quot; support and commitment on implementation of evidence based ACP protocols.</td>
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<td>6 Draft partner agreements sand obtain signatures from partners acknowledging participation and adherence to ACP</td>
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## Project Requirements

### Milestone/Task Name

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<td>protocols, processes and procedures.</td>
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<td>Task 7 Establish partnerships and agreements with social services agencies to assist in the provision of needed services and implement risk reduction, which can include protective services, shelter, housing, food, etc.</td>
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### Milestone #1

Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.

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<th>Project Requirements</th>
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<tr>
<td>Task 1 Develop protocol for identification of Patients at risk for progressing to Health Home eligibility. Protocol shall contain definitions, and intervention through PCPs, Care Managers and Coordinators/Health Homes, and specialists</td>
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<td>Task 2 Develop a health home at risk intervention model with prescribed implementation of Comprehensive Care plans for each patient with a chronic progressive disease. Care plans will be uniform and distributed throughout the PPS provider partners through the provider engagement teams. Short cuts and in-putting and monitoring of these within provider EMRs will be developed and trained by the team.</td>
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<td>Task 3 Disseminate protocol to ACP PCPs to treat patients in accordance with evidence based protocols to include referrals to specialist and social services as necessary.</td>
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<td>Task 4 Develop Care Plan to include patient self-management techniques, disease specific education, how to recognize triggers, remove hazards and avoid complications.</td>
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<td>Task 5 Ensure that Care Plans are created, printed and explained in the language of the patients being served and implemented in a culturally appropriate manner.</td>
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<td><strong>Task</strong> 6 Develop ACP processes and procedures included in protocols to include more stringent care coordination emulating health homes at the Primary Care office with PCMH level standards of care.</td>
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<td><strong>Task</strong> 7 Creation of Central Care Management/Care coordination teams at the level of health Homes through ACP's intense back office/Care Coordination department to provide more centralized, efficient integrated care.</td>
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<td><strong>Milestone #2</strong> Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.</td>
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<td><strong>Task</strong> All practices meet NCQA 2014 Level 3 PCMH and APCM standards</td>
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<td><strong>Task</strong> 1 Leverage ACP's strong PCP network to establish and enhance relationships between partner hospitals and primary care providers for open communication and accessibility.</td>
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<td><strong>Task</strong> 2 Utilize physician engagement teams, IPA groups, and physician champions to engage all PCPs in ACP's network in the participation of DSRIP and educate on the importance of advanced primary care and achievement of NCQA 2014 PCMH certification.</td>
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<td><strong>Task</strong> 3 Contract with PCMH certified professionals that will assist the practices in attaining 2014 NCQA PCMH accreditation by year 3.</td>
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<td><strong>Task</strong> 4 Develop tracking tool linked to physician database to understand progress for each physician undergoing PCMH certification.</td>
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<td><strong>Task</strong> 5 Develop remediation plan with steps for assisting physicians that require additional support in achieving 2014 PCMH level 3 accreditation.</td>
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<td><strong>Milestone #3</strong> Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information</td>
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NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

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<th>Task</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
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<td>among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.</td>
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<td>Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td>Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td>Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td>Task PPS uses alerts and secure messaging functionality.</td>
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<tr>
<td>Task 1 Work with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.</td>
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<td>Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.</td>
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<tr>
<td>Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.</td>
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<td>Task 4 Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.</td>
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<td>Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.</td>
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<td>Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.</td>
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<td>Task 7 Develop final plan for sharing health information among clinical partners by DY3.</td>
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<td>Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes</td>
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NYS Confidentiality – High
## Project Requirements

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<tr>
<td><strong>Task 9</strong></td>
<td>Develop tracking tool linked to physician database to understand physician data sharing activities on health information exchange/RHIO/SHIN-NY.</td>
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<td><strong>Task 10</strong></td>
<td>Periodically review physicians (more frequently at the beginning) to ensure data is being shared and that bi-directional activities are evident.</td>
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<td><strong>Milestone # 4</strong></td>
<td>Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.</td>
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<td><strong>Task</strong></td>
<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
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<td><strong>Task</strong></td>
<td>PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
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<td><strong>Task</strong></td>
<td>Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.</td>
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<td><strong>Task</strong></td>
<td>Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).</td>
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<td><strong>Task</strong></td>
<td>Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.</td>
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<td><strong>Task</strong></td>
<td>Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.</td>
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<td><strong>Task</strong></td>
<td>Develop tracking tool linked to physician database to monitor EHR system use. Additionally, physician process adherence will be tracked (methodologies should follow developed</td>
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<td>protocols and how-to's.</td>
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<td><strong>Task 6</strong></td>
<td>Develop remediation plan with steps for assisting physicians that require additional support in appropriate use of EHR systems to support PCMH requirements.</td>
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<td><strong>Milestone #5</strong></td>
<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
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<td><strong>Task</strong></td>
<td>PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.</td>
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<td><strong>Task 1</strong></td>
<td>Develop and implement algorithm to be used to stratify and identify target patients. Algorithm to include specific chronic disease codes to understand at-risk population.</td>
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<td><strong>Task 2</strong></td>
<td>Develop a strategy with timeline to be used to obtain significant data from EMR registries or from practice management systems. Data should include in all cases patient demographics in addition to the specified data used in the algorithm.</td>
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<td><strong>Task 3</strong></td>
<td>Identify data analytics staff or practice champion to perform the data pulls at the specified times.</td>
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<td><strong>Task 4</strong></td>
<td>Perform comparative analysis using data pulls from ACP central data repository and other platforms such as Salient and MCOs to validate and verify data and implement targeted and population health strategies.</td>
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<td><strong>Milestone #6</strong></td>
<td>Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.</td>
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<td><strong>Task</strong></td>
<td>Procedures to engage at-risk patients with care management plan instituted.</td>
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<tr>
<td><strong>Task 1</strong></td>
<td>Develop comprehensive care plans to distribute throughout the PPS with disease specific education and instruction on self-management, risk reduction, identification and elimination of triggers. The comprehensive care plans also include home assessments and family/caregiver intervention. The Care Plans</td>
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<tr>
<td>will be presented to the patient with appropriate training at the point of care by the Primary Care Provider.</td>
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<td><strong>Task</strong> 2 Create a back office protocol that consists of outreach staff, care coordinators that will remain in contact with the patients, establish a rapport with the patient and caregiver/family to ensure that communication gaps and patient discomfort levels are resolved. The number of calls and follow ups per week/month will vary depending on patient's health status and patient's health literacy rates. Care Coordinators will ensure that appointments are made and kept, transportation is made available whenever necessary, orders are fulfilled and the patient receives any needed care.</td>
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<tr>
<td><strong>Task</strong> 3 Hire and train Care Managers in the back office to also be readily available to the patients and reach out and be manage their care ie. Medications, counsel, etc. thus ensuring that the patient has what he/she needs for management of disease and increased quality of life.</td>
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<td><strong>Milestone #7</strong> Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.</td>
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<td><strong>Task</strong> Each identified PCP establish partnerships with the local Health Home for care management services.</td>
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<td><strong>Task</strong> Each identified PCP establish partnerships with the local Health Home for care management services.</td>
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<td><strong>Task</strong> 1 Develop protocols in which each entities roles are delineated. Protocol should clearly establish the primary care provider’s responsibility, care plan implementation, as well as health home eligibility and the roles of the health home.</td>
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<td><strong>Task</strong> 2 ACP will leverage its partner Health Homes and establish clear partnerships with the HH and PCPs through its regional Care Teams. ACP’s care Teams are comprised of partners within a given region and they include providers of all types including HHs. Health Homes will be linked and partnered with the PCPs within their regions. The HHs and PCPs will collaborate in accordance with the set protocols and processes.</td>
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<td>ACP has a vast number of patients, due to this, ACP will work with the HHs in the network to incorporate best practices and processes into a back office/care coordination team that will provide additional, enhanced care coordination and management.</td>
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<td>Primary Care Provider’s role shall be as per the protocol to provide evidence based disease management, implementing a comprehensive care plan for specific disease management. PCP office will work with Care Coordination team in Health Home model care coordination</td>
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<td>Health Homes’ role shall be to provide guidance, assistance and support in the implementation of a Health Home model of Care Coordination as well as provide Health Home services as needed for patients eligible to receive care under the Medicaid Health Home eligibility criteria.</td>
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<td>Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).</td>
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<td>PPS has established partnerships to medical, behavioral health, and social services.</td>
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<td>PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.</td>
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<td>Establish relationships and partnership with Behavioral Health, OASAS, OMH entities and engage in a service agreement. Engage these entities in all regions and counties in which ACP serves.</td>
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<tr>
<td>Establish relationships with local government, social and specialty services such as SPOAs, agencies for the developmentally disabled to coordinate and provide needed services to patients.</td>
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<tr>
<td>Task 11</td>
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<tr>
<td>Include identified entities in Care Teams, PAC, Clinical</td>
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### Project Requirements

<table>
<thead>
<tr>
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<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
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<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Committees to help develop, coordinate and disseminate best practices, protocols, etc and provide higher quality service.</td>
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<tr>
<td><strong>Task</strong> 4 Liaise and form partnerships between these entities and the PCP especially in areas where these services have been lacking and patient are going without needed care and services.</td>
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<tr>
<td><strong>Task</strong> 5 ACP will implement a referral process by which all referrals are entered and submitted via the EMR and go through an HIE. ACP partners’ and associated providers’ information shall be uploaded and prompted to the PCP or other referrer as a referral database so that referrals can be made to the needed service provider or agency that has made a commitment to tend to ACP patients in the specified timeframe and manner.</td>
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<tr>
<td><strong>Task</strong> 6 All referrals shall go through to the ACP central data repository and shall be stored and documented for monitoring and adherence to procedure.</td>
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<tr>
<td><strong>Task</strong> 7 Referrals going through ACP’s HIE are picked up and are monitored by the ACP central care coordinators to ensure completeness and attainment of services in a timely and efficient manner and for further care coordination.</td>
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<tr>
<td><strong>Milestone #9</strong> Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.</td>
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<tr>
<td><strong>Task</strong> PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.</td>
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<tr>
<td><strong>Task</strong> Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.</td>
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<tr>
<td><strong>Task</strong> PPS has included social services agencies in development of risk reduction and care practice guidelines.</td>
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<tr>
<td><strong>Task</strong> Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.</td>
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## Advocate Community Providers, Inc.  (PPS ID:25)

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<th>Project Requirements (Milestone/Task Name)</th>
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<tbody>
<tr>
<td>Task</td>
</tr>
<tr>
<td>1 ACP will develop and implement best practices in care management and care coordination in conjunction with Health Home partners and develop evidence based protocols for disease management.</td>
</tr>
<tr>
<td>Task</td>
</tr>
<tr>
<td>2 Develop uniform Comprehensive Care plans which will include disease self management techniques and will also include risk reduction activities, recognizing of warning signs and family education and support materials. The Care plans will be in different languages to be given to the patient's of ACP in their appropriate language. Furthermore, the Care plans will be consistent with the Cultural sensitivities of the population/patient being served.</td>
</tr>
<tr>
<td>Task</td>
</tr>
<tr>
<td>3 Develop Evidence based protocols for chronic diseases with the help of Primary care physicians, specialists physicians and associations such as JNC-8, American Lung Association, etc.</td>
</tr>
<tr>
<td>Task</td>
</tr>
<tr>
<td>4 Disseminate protocols to all providers within the PPS through physician engagement meetings, physician engagement teams and IPAs.</td>
</tr>
<tr>
<td>Task</td>
</tr>
<tr>
<td>5 With the help of the IPAs, physician champions, the PAC, and other committees, obtain physician &quot;buy-in&quot; support and commitment on implementation of evidence based ACP protocols.</td>
</tr>
<tr>
<td>Task</td>
</tr>
<tr>
<td>6 Draft partner agreements sand obtain signatures from partners acknowledging participation and adherence to ACP protocols, processes and procedures.</td>
</tr>
<tr>
<td>Task</td>
</tr>
<tr>
<td>7 Establish partnerships and agreements with social services agencies to assist in the provision of needed services and implement risk reduction, which can include protective services, shelter, housing, food, etc.</td>
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### Prescribed Milestones Current File Uploads

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NYS Confidentiality – High
### Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Ensure that all participating 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.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public...</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
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### Prescribed Milestones Narrative Text

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<tr>
<th>Milestone Name</th>
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<tbody>
<tr>
<td>Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.</td>
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### IPQR Module 2.a.iii.5 - PPS Defined Milestones

**Instructions:**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

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<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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### PPS Defined Milestones Narrative Text

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IPQR Module 2.a.iii.6 - IA Monitoring

Instructions:

Milestone 2: Develop progress tracking and monitoring system to allow for adjustments and changes to achieve identified targets.

Milestone 3: Develop progress tracking and monitoring system to allow for adjustments and changes to achieve identified targets.

Milestone 4: Develop progress tracking and monitoring system to allow for adjustments and changes to achieve identified targets.

Milestone 7: The IA recommends adding steps to delineate the roles and responsibilities for both parties.
Project 2.b.iii – ED care triage for at-risk populations

Instructions:

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Risk #1: Failing to close gap in the physician/patient relationship: Many cultures within our geographies are biased towards going to the ED for all care, as they see it as more convenient and immediately responsive than going to a PCP. Our PPS plans to provide population wide education and awareness campaigns to emphasize the importance of remaining connected to a Primary Care provider, working alongside our community organization partners to expand outreach into the many ethnic groups represented in the population. Additionally, the ED triage process that will be established will include a robust team of Patient Navigators available to every patient. They will connect the patient with their existing PCP, link those without a PCP to an ACP primary care provider, and schedule a timely appointment with a PCP before leaving the ED using ACP's integrated platform or the PCP's EHR portal.

Risk #2: Capacity of PCPs/Alternative Sites of Care: Our PPS is serves an underserved area with low capacity for new appointments; throughout our communities, appointment wait times of 4+ days are not uncommon. Success will require PCPs to create greater capacity and possibly extend their work hours. ACP plans to address this challenge by providing support and training to the PCPs and staff to help make their practices more efficient and patient care more satisfying. ACP will also make available Care Managers that may be able to lighten the load for the PCP through participation in patient care. Additionally, this project may create the need for additional alternative sites of care such as urgent care which ACP will be building out and staffing.

Risk #3: Lack of communications among providers: Given the unique structure of our PPS that spans more than 2,000 physicians and community based providers, communication and information sharing could pose a potential challenge. We will address this through a robust, integrated technology platform that will be accessible across all of our providers. Additionally, this initiative will rely heavily on our capability to communicate with other PPS' in our area that are also participating in the initiative. We are currently building capabilities alongside our IT vendor, eCW, and will also leverage the SHIN-NY and RHIO platforms to assist in this task.

Risk #4: Need for capital funding grant and construction: Some triage protocols can be done in existing space, but to achieve the goals we defined, there will be a need for newly constructed space.

NYS Confidentiality – High
IPQR Module 2.b.iii.2 - Project Implementation Speed

Instructions:

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.

Note: data entered into this table must represent CUMULATIVE figures.

### Benchmarks

<table>
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<tr>
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<tr>
<td>Emergency Departments with Care Triage</td>
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<tr>
<td>Total Committed Providers</td>
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<td>Percent Committed Providers(%)</td>
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<td>Total Committed Providers</td>
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<tr>
<td>Percent Committed Providers(%)</td>
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Current File Uploads

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Narrative Text:

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
Instructions:

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application. Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
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<td>Patients Engaged</td>
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<td>10,833</td>
<td>14,896</td>
<td>18,958</td>
<td>23,021</td>
<td>27,083</td>
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<th>DY5,Q3</th>
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<td>Patients Engaged</td>
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<td>54,167</td>
<td>10,427</td>
<td>29,791</td>
<td>41,979</td>
<td>54,167</td>
<td>10,427</td>
<td>29,791</td>
<td>41,979</td>
<td>54,167</td>
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<td>Percent of Expected Patient Engagement(%)</td>
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<td>100.00</td>
<td>19.25</td>
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IPQR Module 2.b.iii.4 - Prescribed Milestones

Instructions:

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

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<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>Milestone #1 Establish ED care triage program for at-risk populations</td>
<td>Project</td>
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<td>06/30/2016</td>
<td>06/30/2016</td>
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<tr>
<td>Task Stand up program based on project requirements</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 1 Developed processes and procedures to be implemented by partner hospitals in a uniform manner that will allow for efficient ED triage, treat and release.</td>
<td>Project</td>
<td>N/A</td>
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<td>04/01/2015</td>
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<td>Task a Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.</td>
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<tr>
<td>Task b Develop process and procedures to establish connectivity between the emergency department and community primary care providers.</td>
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<td>Safety Net Primary Care Physicians</td>
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<td>Task c Ensure real time notification to a Health Home care manager as applicable.</td>
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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name)

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<td>Task 10 The hospital feeds will be sent/received into the PCP's EMR, ACP's FTP site and as well as ACP's central care coordination/back office.</td>
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| Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider:  
a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.  
b. Patient navigator will assist the patient with identifying and accessing needed community support resources.  
c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider). | Project         | In Progress   | 04/01/2015| 12/31/2015| 12/31/2015 | DY1 Q3           |                               |
| Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place. | Project         | In Progress   | 04/01/2015| 12/31/2015| 12/31/2015 | DY1 Q3           |                               |
| Task 1 ACP will employ Patient navigators in the ED that will assist the patients in the emergency room. | Project         | In Progress   | 04/01/2015| 12/31/2015| 12/31/2015 | DY1 Q3           |                               |
| Task 2 Train the patient navigators to educate the patient once treated and ensure that the patient receives information on and receives and appointment to a 2014 PCMH Primary Care provider. | Project         | In Progress   | 04/01/2015| 12/31/2015| 12/31/2015 | DY1 Q3           |                               |
| Task 3 Patient navigator will provide the patient with the appointment before the patient is discharged and will work with care coordinator in ensuring that the patient has and is able to access necessary support in the community. | Project         | In Progress   | 04/01/2015| 12/31/2015| 12/31/2015 | DY1 Q3           |                               |
| Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.) | Project         | N/A           | On Hold   | 04/01/2015| 03/31/2020 | 03/31/2020 | DY5 Q4                        |
| Task PPS has protocols and operations in place to transport non-acute patients to Provider Safety Net Hospitals | Provider        | On Hold       | 04/01/2015| 03/31/2020| 03/31/2020 | DY5 Q4                        |                               |
Advocate Community Providers, Inc. (PPS ID:25)

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<td>Use EHRs and other technical platforms to track all patients engaged in the project.</td>
<td>Project</td>
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<tr>
<td>Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
<td>Project</td>
<td>In Progress</td>
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<tr>
<td>Task 1 PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
<td>Project</td>
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<tr>
<td>Task 2 Data held and analyzed will include hospital encounter to PCP follow up visits, number of follow up visits, lag time between ER encounter, date and time appointment made and date of appointment.</td>
<td>Project</td>
<td>In Progress</td>
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<td>DY2 Q1</td>
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<tr>
<td>Task 3 ACP will gather utilization data from within hospital EMR, PCP EMR and even partner EMRs. Hospital ER use and monitor and stratify based on patient condition, frequency of utilization, etc. as per algorithm which will then be fed to Care Managers and Care Coordinators and CHWs to reach out to patients, provide education, self-management techniques, medication reconciliations including refills, will connect the patient with needed social and community services, and other needed services.</td>
<td>Project</td>
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<tr>
<td>Task</td>
<td>Establish ED care triage program for at-risk populations</td>
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<tr>
<td>Task</td>
<td>Stand up program based on project requirements</td>
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<tr>
<td>Task</td>
<td>1 Developed processes and procedures to be implemented by partner hospitals in a uniform manner that will allow for efficient ED triage, treat and release.</td>
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<td>Task</td>
<td>2 Develop and implement algorithm for stratifying and identifying at risk populations for early intervention. Algorithm to include those with ICDs with high HCC scores, hospital</td>
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NYS Confidentiality – High
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Advocate Community Providers, Inc. (PPS ID:25)

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Milestone #3  
For patients presenting with minor illnesses who do not have a primary care provider:  
a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.
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<td>Use EHRs and other technical platforms to track all patients</td>
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<td>algorithm and continuously analyze the data which will be</td>
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**New York State Department Of Health**

**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**

**Advocate Community Providers, Inc. (NYS ID:25)**

**NYS Confidentiality – High**
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<td>3 ACP will gather utilization data from within hospital EMR, PCP EMR and even partner EMRs. Hospital ER use and monitor and stratify based on patient condition, frequency of utilization, etc., as per an algorithm which will then be fed to Care Managers and Care Coordinators and CHWs to reach out to patients, provide education, self-management techniques, medication reconciliations including refills, will connect the patient with needed social and community services, and other needed services.</td>
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<tr>
<td>Establish ED care triage program for at-risk populations</td>
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<td>Stand up program based on project requirements</td>
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<tr>
<td>1 Developed processes and procedures to be implemented by partner hospitals in a uniform manner that will allow for efficient ED triage, treat and release.</td>
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<tr>
<td>2 Develop and implement algorithm for stratifying and identifying at-risk populations for early intervention. Algorithm to include those with ICDs with high HCC scores, hospital utilization, high utilizers with negative workups, SUD, high PHQ9 and GAD scores, among other criteria.</td>
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<td>3 Develop patient education materials to provide patients upon release to increase health literacy and orient patients as to proper use of ER resources.</td>
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<tr>
<td>4 Employ and utilize patient navigators which will educate patients and coordinate care so that the patient will leave the hospital ED with a prearranged appointment to his/her PCP, if patient has no connection to a PCP then an introduction and connection shall be made with a PCMH provider within the ACP network.</td>
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**NYS Confidentiality – High**
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<th>Task</th>
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<td><strong>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.</strong></td>
<td>524 748 748 748 748 748 748 748 748 748</td>
</tr>
<tr>
<td><strong>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)</strong></td>
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<tr>
<td><strong>Encounter Notification Service (ENS) is installed in all PCP offices and EDs</strong></td>
<td>524 748 748 748 748 748 748 748 748 748</td>
</tr>
<tr>
<td><strong>1</strong></td>
<td>Leverage ACP’s strong PCP network to establish and enhance relationships between partner hospitals and primary care providers for open communication and accessibility.</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Utilize physician engagement teams, IPA groups, and physician champions to engage all PCPs in ACP’s network in the participation of DSRIP and educate on the importance of advanced primary care and achievement of NCQA 2014 PCMH certification.</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Leverage partnerships with Health Homes and establish connectivity to these to ensure that patient information is sent in real time to Health Homes as needed due to patient’s condition so patient is connected to health home for further care.</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>Perform IT surveys to identify provider EMR readiness, transition from paper and specific EMRs with specific detail to whether MU2 ready and MU2 status.</td>
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<tr>
<td><strong>5</strong></td>
<td>Negotiate with EMR vendors to provide implementation and compliance.</td>
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**NYS Confidentiality – High**
## Project Requirements

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<tr>
<td>support assistance to all providers as needed in attainment of MU2 certification.</td>
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<td><strong>Task 1</strong> Establish ACP IT support team in conjunction with physician engagement team to provide support and assistance to providers in MU and PCMH certification.</td>
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<tr>
<td><strong>Task 2</strong> Create IDS to provide timely and efficient communication and scheduling amongst all of ACP’s partners, (hospitals and PCPs) as well as provide notifications to PCPs and Health Homes as appropriate.</td>
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<tr>
<td><strong>Task 3</strong> As the ramp up and build out of the IDS occurs, ACP will use hospital EHRs, FTP site, and PCP’s EMR to exchange information on patients that are received and treated in the ER.</td>
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<tr>
<td><strong>Task 4</strong> Interim step: Set up relationships and connections within hospital EHRs such as EPIC et al. that provide ADT feeds to ACP’s central care coordination/back office team who accept the information and process appointment follow up.</td>
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<td><strong>Task 5</strong> The hospital feeds will be sent/received into the PCP’s EMR, ACP’s FTP site and as well as ACP’s central care coordination/back office.</td>
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<td><strong>Milestone #3</strong> For patients presenting with minor illnesses who do not have a primary care provider:</td>
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<td>a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.</td>
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<td></td>
</tr>
<tr>
<td><strong>Task</strong> 3 ACP will Gather utilization data from within hospital EMR, PCP EMR and even partner EMRs. Hospital ER use and monitor and stratify based on patient condition, frequency of utilization, etc. as per algorithm which will then be fed to Care Managers and Care Coordinators and CHWs to reach out to patients, provide education, self-management techniques, medication reconciliations including refills, will connect the patient with needed social and community services, and other needed services.</td>
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Prescribed Milestones Current File Uploads

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Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
</table>
| Establish ED care triage program for at-risk populations | Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling.  
  a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.  
  b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers.  
  c. Ensure real time notification to a Health Home care manager as applicable.  

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments. |
| For patients presenting with minor illnesses who do not have a primary care provider:  
  a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need.  
  b. Patient navigator will assist the patient with identifying and accessing needed community support resources.  
  c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).  
| Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care.  

NYS Confidentiality – High
<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>(This requirement is optional.)</td>
<td>Use EHRs and other technical platforms to track all patients engaged in the project.</td>
</tr>
</tbody>
</table>
**IPQR Module 2.b.iii.5 - PPS Defined Milestones**

**Instructions:**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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**PPS Defined Milestones Current File Uploads**

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**PPS Defined Milestones Narrative Text**

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<th>Milestone Name</th>
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IPQR Module 2.b.iii.6 - IA Monitoring

Instructions:

NYS Confidentiality – High
Project 2.b.iv – Care transitions intervention model to reduce 30 day readmissions for chronic health conditions

IPQR Module 2.b.iv.1 - Major Risks to Implementation and Mitigation Strategies

Instructions:

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

The major risks for this project revolve around being granted access to those hospitals who are leads in other PPS' in order to obtain patient information and patient access. Patient engagement consists of performing pre-discharge planning and the performance itself is based on providing transitional care visits to ensure stable transition and eliminate/prevent 30 day re-admissions. Without proper, timely access to the patient information and to the patient, this process is hindered. A comprehensive, effective transitional care visit which includes comprehensive medication reconciliation and effective implementation of a comprehensive plan of care are heavily reliant on having accurate information regarding both the hospital stay and the discharge plan, without access to discharge information and discharge papers, this process is impeded.

To mitigate this issue, ACP is avidly reaching out to and negotiating with all of the hospitals in ACP's catchment area and to which any patient attributed to ACP may receive services from without regard to the PPS that they participate in. ACP will use MCO feeds, patient notices and other resources to reach patients as early as possible while the negotiations are going on and while the connection to RHIOs is being worked out.
### IPQR Module 2.b.iv.2 - Project Implementation Speed

**Instructions:**

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application. Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year, Quarter (DY1,Q1 – DY3,Q2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>902</td>
<td>0</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>1,428</td>
<td>0</td>
</tr>
<tr>
<td>Hospitals</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>1,418</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>3,785</td>
<td>0</td>
</tr>
<tr>
<td>Percent Committed Providers (%)</td>
<td>0.00</td>
<td>0.00</td>
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</table>

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year, Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>DY3,Q3</td>
<td>DY3,Q4</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>902</td>
<td>902</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>1,428</td>
<td>1,428</td>
</tr>
<tr>
<td>Hospitals</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>All Other</td>
<td>1,418</td>
<td>1,418</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>3,785</td>
<td>3,785</td>
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<tr>
<td>Percent Committed Providers (%)</td>
<td>100.00</td>
<td>100.00</td>
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NYS Confidentiality – High
Advocate Community Providers, Inc. (PPS ID:25)

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Narrative Text:

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc. (PPS ID:25)

IPQR Module 2.b.iv.3 - Patient Engagement Speed

Instructions:

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.

Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>150</td>
<td>20,497</td>
<td>26,646</td>
<td>32,795</td>
<td>36,895</td>
<td>40,994</td>
<td>61,491</td>
<td>81,988</td>
<td>15,783</td>
<td>45,093</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>0.18</td>
<td>25.00</td>
<td>32.50</td>
<td>40.00</td>
<td>45.00</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
<td>19.25</td>
<td>55.00</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>63,541</td>
<td>81,988</td>
<td>15,783</td>
<td>45,093</td>
<td>63,541</td>
<td>81,988</td>
<td>15,783</td>
<td>45,093</td>
<td>63,541</td>
<td>81,988</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>77.50</td>
<td>100.00</td>
<td>19.25</td>
<td>55.00</td>
<td>77.50</td>
<td>100.00</td>
<td>19.25</td>
<td>55.00</td>
<td>77.50</td>
<td>100.00</td>
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</table>

Narrative Text:

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
**IPQR Module 2.b.iv.4 - Prescribed Milestones**

Instructions:

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>1 Develop Care transitions intervention model to include pre-discharge and post discharge patient contact, assessment and intervention.</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>2 Develop pre-discharge plan template using evidence based standards in accordance with national standards</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>3 Review pre-discharge plan requirements with partner hospitals and ensure that pre-discharge plans are standard and meet ACP’s standards both in components and timing.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>4 Develop reporting methods for monitoring pre-discharge plans performed in the inpatient hospital setting.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>5 Convene Transitional Care project physician leads to draft, review and approve evidence based protocol for care transitions post discharge visit.</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>6 Develop and implement standardized protocol for transitional care visits which include comprehensive medication reconciliation, assessments and interventions for conditions that have the highest incidence of hospital readmissions and the performance of which have proven to reduce re-hospitalizations such as fall risk assessments and implementing fall risk reduction plans amongst others. The protocol also calls for assessing patient’s overall needs including social support referrals, DMEs, specialty services, home care, etc. for providing care for the patient in a team approach.</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Reporting Level</td>
<td>Provider Type</td>
<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
</tr>
<tr>
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<td>----------------------------------</td>
</tr>
<tr>
<td>7 Engage home care service agencies, social service agencies, home delivery services, and others as partners of the PPS to provide needed services to ACP patients. These agencies will serve on ACP’s care Teams, PAC, Clinical Quality committees to assist the PPS in providing a team approach to patient care.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>8 Disseminate post discharge standardized protocol to ACP providers using ACP’s provider engagement teams, PAC, Care Teams, etc.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Milestone #2</td>
<td>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.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
</tr>
<tr>
<td>Task</td>
<td>A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task</td>
<td>Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task</td>
<td>PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task</td>
<td>1 Disseminate care transitions protocols to MCOs and health homes working with ACP for the implementation.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task</td>
<td>2 Liaise and Coordinate between MCOs and Health Homes in the provision and coverage for services needed during the post discharge period.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task</td>
<td>3 Forge relationships with upper management at MCOs and Health Homes to bring appropriate level individuals to the negotiations table.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2016</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task</td>
<td>4 Elaborate and Negotiate a payment strategy for transitional care visits including those done at PCP’s office and those done at the patient’s home as needed.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task</td>
<td>5 Elaborate and negotiate a payment for services rendered in the Care Management and care coordination of transitional care services in coordination with the Health homes.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

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<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Establish care coordination/back office team to receive feeds/reports from inpatient hospitals, MCOs and implement care coordination immediately to facilitate and ensure higher compliance rate and higher patient engagement rates.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>7 Establish Care Coordination processes and procedures indicating receipt of feed and processing of the information in a timely manner, attainment of pre-discharge plans, coordinating of care through social supports, specialty, home care, delivery and transitional care post discharge visits.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>8 Establish care Coordination platform, EMR, by which all data, patient information will be tracked.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td>9 Establish clear lines of communication between ACP central care coordination and outreach and the Health Homes within the network.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>10 Develop and Implement Health Home protocol that includes a clear definition of Health Home eligible and a clear process by which patient shall be linked to the Health Home.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>11 Train all care managers and care coordinators on Health Home eligibility and process for referring.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>12 Train all ACP providers on Health Home eligibility and process for referring.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Milestone #3 Ensure required social services participate in the project.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Required network social services, including medically tailored home food services, are provided in care transitions.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>1 Engage social service and social support entities in ACP's network.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>2 Incorporate social service and social support entities in ACP Care Teams and PAC. Social support services such as meal delivery services, God's Love we Deliver: Interim housing/shelters such as VIP are a part of ACP's network, Care Teams and PAC.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Milestone #4 Transition of care protocols will include early notification of planned discharges</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Project Requirements (Milestone/Task Name)</td>
<td>Reporting Level</td>
<td>Provider Type</td>
<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
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<tr>
<td>and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.</td>
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</tr>
<tr>
<td><strong>Task</strong> Policies and procedures are in place for early notification of planned discharges.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Policies and procedures are in place for early notification of planned discharges.</td>
<td>Provider</td>
<td>Non-PCP Practitioners</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Policies and procedures are in place for early notification of planned discharges.</td>
<td>Provider</td>
<td>Hospitals</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> ACP has worked with and negotiated with hospital partners and hospitals in other PPS, the hospitals will provide transition care managers and/or pre-discharge planners to develop and review discharge planning while the patient is still inpatient. The discharge plan and summary will be made available to the TC partner and to the PCP for more accurate and efficient treatment. The pre-discharge plan will also be used to coordinate needed services such as social support, home care, DME, etc. and the Transitional Care visit.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> 1 Establish processes with partner hospitals in which a care transitions/pre-discharge plan nurse or care manager establishes the link with the patient and provides the pre-discharge plan at the patient's side, while the patient is still inpatient in accordance with the established transitional care protocol and standardized pre-discharge plan.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> 2 Partner hospital will allow access to the patient to the care transition pre-discharge plan manager/nurse and in most cases the care manager/nurse will be a hospital staff member since ACP's partner hospitals have care transitions staff already on hand.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 3 Processes are in place to receive feeds from hospitals and MCOs on a daily basis of all admissions allowing for early notification of hospitalizations and thereby early access to patients for the provision of discharge planning.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong> 4 Processes and procedures are in place for prompt action upon receipt of the</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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</tbody>
</table>
**Project Requirements (Milestone/Task Name)** | **Reporting Level** | **Provider Type** | **Status** | **Start Date** | **End Date** | **Quarter End Date** | **DSRIP Reporting Year and Quarter**
---|---|---|---|---|---|---|---

**Milestone #5**  
Protocols will include care record transitions with timely updates provided to the members’ providers, particularly primary care provider.

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<tr>
<th>Task</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
</tbody>
</table>

**Task**  
1 Develop processes as mandated by protocol for transmission of Care transitions records to member's provider/PCP within 48 hours of Transitional Care visit.

<table>
<thead>
<tr>
<th>Task</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
</tbody>
</table>

Task  
2 Utilizing guidelines from the National Transition of Care Coalition and working with the expertise of ACP partners who specialize in Care Transitions, ACP will bring together a standardized protocol/standard of care and processes for providing quality Care Transitions services. Protocol/Standard of Care to include comprehensive medication reconciliation, comprehensive evaluation, HEDIS assessments, ADL assessments, Fall risk, etc.

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<thead>
<tr>
<th>Task</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
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<tr>
<td>Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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</table>

Task  
3 Implement process as mandated by protocol by which member's provider/PCP receives Transitional Care visit records within 48hours.

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<tr>
<th>Task</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
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<tbody>
<tr>
<td>Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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</table>

**Milestone #6**  
Ensure that a 30-day transition of care period is established.

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<th>Task</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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</table>

Task  
1 Implement care transition protocol mandate calculation of 30 day period to start on the date of discharge as day 0 and the day following discharge as day 1 up to 30 calendar days.

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<tr>
<th>Task</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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</table>

**Milestone #7**  
Use EHRs and other technical platforms to track all patients engaged in the project.

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<thead>
<tr>
<th>Task</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
<td>Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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Task  
2 Utilizing guidelines from the National Transition of Care Coalition and working with the expertise of ACP partners who specialize in Care Transitions, ACP will bring together a standardized protocol/standard of care and processes for providing quality Care Transitions services. Protocol/Standard of Care to include comprehensive medication reconciliation, comprehensive evaluation, HEDIS assessments, ADL assessments, Fall risk, etc.

<table>
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<tr>
<th>Task</th>
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<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
<td>Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**

**Advocate Community Providers, Inc.  (PPS ID:25)**

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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</tr>
<tr>
<td><strong>Task</strong> 1 Processes are in place in which upon receipt of inpatient feeds, Care Transitions team ensures that all relevant patient data including diagnoses, demographics, etc. are entered into EMR.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 2 Utilizing Care transitions team's EMR structured fields all patient data is entered, gathered and filtered for evaluation of engagement efforts, successes and improvements.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong> 3 Data mining from Care Transitions team's EMR and additional electronic systems are used to provide stratification, target identification and outreach population wide, patient specific and overall tracking and reporting.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong> 4 Additional data filters and repositories are created within hospital EMR, ACP central Care Coordination systems for redundancy, data verification and comparison analytics.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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</tbody>
</table>

| Milestone #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. |                  |               |            |            |          |                 |                                  |
| **Task** Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place. |                  |               |            |            |          |                 |                                  |
| **Task** 1 Develop Care transitions intervention model to include pre-discharge and post discharge patient contact, assessment and intervention. |                  |               |            |            |          |                 |                                  |
| **Task** 2 Develop pre-discharge plan template using evidence based standards in accordance with national standards |                  |               |            |            |          |                 |                                  |
| **Task** 3 Review pre-discharge plan requirements with partner hospitals and ensure that pre-discharge plans are standard and meet ACP's standards both in components and timing. |                  |               |            |            |          |                 |                                  |

NYS Confidentiality – High
<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 4 Develop reporting methods for monitoring pre-discharge plans performed in the inpatient hospital setting.</td>
<td></td>
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<tr>
<td>Task 5 Convene Transitional Care project physician leads to draft, review and approve evidence based protocol for care transitions post discharge visit.</td>
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<tr>
<td>Task 6 Develop and implement standardized protocol for transitional care visits which include comprehensive medication reconciliation, assessments and interventions for conditions that have the highest incidence of hospital readmissions and the performance of which have proven to reduce re-hospitalizations such as fall risk assessments and implementing fall risk reduction plans amongst others. The protocol also calls for assessing patient's overall needs including social support referrals, DMEs, specialty services, home care, etc. for providing care for the patient in a team approach.</td>
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<tr>
<td>Task 7 Engage home care service agencies, social service agencies, home delivery services, and others as partners of the PPS to provide needed services to ACP patients. These agencies will serve on ACP's care Teams, PAC, Clinical Quality committees to assist the PPS in providing a team approach to patient care.</td>
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<td>Task 8 Disseminate post discharge standardized protocol to ACP providers using ACP's provider engagement teams, PAC, Care Teams, etc.</td>
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<tr>
<td>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.</td>
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<tr>
<td>A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.</td>
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<td>Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.</td>
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<td>PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.</td>
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## Project Requirements

### (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Project Requirements</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
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<th>DY1,Q4</th>
<th>DY2,Q1</th>
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<td><strong>Task</strong></td>
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<tr>
<td>1 Disseminate care transitions protocols to MCOs and health homes working with ACP for the implementation.</td>
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<tr>
<td>2 Liaise and Coordinate between MCOs and Health Homes in the provision and coverage for services needed during the post discharge period.</td>
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<tr>
<td>3 Forge relationships with upper management at MCOs and Health Homes to bring appropriate level individuals to the negotiations table.</td>
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<tr>
<td>4 Elaborate and Negotiate and a payment strategy for transitional care visits including those done at PCP's office and those done at the patient's home as needed.</td>
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<td>5 Elaborate and negotiate a payment for services rendered in the Care Management and care coordination of transitional care services in coordination with the Health homes.</td>
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<td>6 Establish care coordination/back office team to receive feeds/reports from inpatient hospitals, MCOs and implement care coordination immediately to facilitate and ensure higher compliance rate and higher patient engagement rates.</td>
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<tr>
<td>7 Establish Care Coordination processes and procedures indicating receipt of feed and processing of the information in a timely manner, attainment of pre-discharge plans, coordinating of care through social supports, specialty, home care, delivery and transitional care post discharge visits.</td>
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<td>8 Establish care Coordination platform, EMR, by which all data, patient information will be tracked.</td>
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<td>9 Establish clear lines of communication between ACP central care coordination and outreach and the Health Homes within the network.</td>
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<td>10 Develop and Implement Health Home protocol that includes a clear definition of Health Home eligible and a clear process by which patient shall be linked to the Health Home.</td>
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<td>11 Train all care managers and care coordinators on Health Home eligibility and process for referring.</td>
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NYS Confidentiality – High
**Project Requirements (Milestone/Task Name)**

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<th>Task</th>
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<th>DY1,Q2</th>
<th>DY1,Q3</th>
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<th>DY2,Q4</th>
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<tr>
<td>12 Train all ACP providers on Health Home eligibility and process for referring.</td>
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<td>Milestone #3 Ensure required social services participate in the project.</td>
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<td>Required network social services, including medically tailored home food services, are provided in care transitions.</td>
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<tr>
<td>1 Engage social service and social support entities in ACP’s network.</td>
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<tr>
<td>2 Incorporate social service and social support entities in ACP Care Teams and PAC. Social support services such as meal delivery services, God’s Love We Deliver; Interim housing/shelters such as VIP are a part of ACP’s network, Care Teams and PAC.</td>
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<td>Milestone #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.</td>
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<td>Policies and procedures are in place for early notification of planned discharges.</td>
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<tr>
<td>Policies and procedures are in place for early notification of planned discharges.</td>
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<td>PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.</td>
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<td>ACP has worked with and negotiated with hospital partners and hospitals in other PPS', the hospitals will provide transition care managers and/or pre-discharge planners to develop and review discharge planning while the patient is still inpatient. The discharge plan and summary will be made available to the TC partner and to the PCP for more accurate and efficient treatment. The pre-discharge plan will also be used to coordinate needed services such as social support, home care, DME, etc. and the Transitional Care visit.</td>
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**NYS Confidentiality – High**
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<th>Project Requirements (Milestone/Task Name)</th>
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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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</thead>
<tbody>
<tr>
<td><strong>Task</strong> 1 Establish processes with partner hospitals in which a care transitions/pre-discharge plan nurse or care manager establishes the link with the patient and provides the pre-discharge plan at the patient's side, while the patient is still inpatient in accordance with the established transitional care protocol and standardized pre-discharge plan.</td>
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<td><strong>Task</strong> 2 Partner hospital will allow access to the patient to the care transition pre-discharge plan manager/nurse and in most cases the care manager/nurse will be a hospital staff member since ACP's partner hospitals have care transitions staff already on hand.</td>
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<td><strong>Task</strong> 3 Processes are in place to receive feeds from hospitals and MCOs on a daily basis of all admissions allowing for early notification of hospitalizations and thereby early access to patients for the provision of discharge planning.</td>
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<td><strong>Task</strong> 4 Processes and procedures are in place for prompt action upon receipt of the inpatient data feeds to begin the process of accessing the patient and implementing the plan.</td>
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<td><strong>Milestone #5</strong> Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.</td>
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<td><strong>Task</strong> Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.</td>
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<tr>
<td><strong>Task</strong> 1 Develop processes as mandated by protocol for transmission of Care transitions records to member's provider/PCP within 48 hours of Transitional Care visit.</td>
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<td><strong>Task</strong> 2 Utilizing guidelines from the National Transition of Care Coalition and working with the expertise of ACP partners who specialize in Care Transitions, ACP will bring together a standardized protocol/standard of care and processes for providing quality Care Transitions services. Protocol/Standard of Care to include comprehensive medication reconciliation, comprehensive evaluation, HEDIS assessments, ADL assessments, Fall risk, etc.</td>
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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name)

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<th>DY2,Q4</th>
<th>DY3,Q1</th>
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<tbody>
<tr>
<td>Implement process as mandated by protocol by which member's provider/PCP receives Transitional Care visit records within 48 hours.</td>
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<td>Utilize EMR to transmit records to member's provider via P2P portal, FTP, HIE, RHIO or ACP platform to be created.</td>
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<td>Ensure that a 30-day transition of care period is established.</td>
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<td>Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.</td>
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<td>Implement care transition protocol mandate calculation of 30 day period to start on the date of discharge as day 0 and the day following discharge as day 1 up to 30 calendar days.</td>
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<td>Use EHRs and other technical platforms to track all patients engaged in the project.</td>
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<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td>Processes are in place in which upon receipt of inpatient feeds, Care Transitions team ensures that all relevant patient data including diagnoses, demographics, etc. are entered into EMR.</td>
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<td>Utilizing Care transitions team's EMR structured fields all patient data is entered, gathered and filtered for evaluation of engagement efforts, successes and improvements.</td>
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<td>Data mining from Care Transitions team's EMR and additional electronic systems are used to provide stratification, target identification and outreach population wide, patient specific and overall tracking and reporting.</td>
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<td>Additional data filters and repositories are created within hospital EMR, ACP central Care Coordination systems for redundancy, data verification and comparison analytics.</td>
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## Milestone #1

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<td>Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.</td>
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<td><strong>Task</strong> Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.</td>
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<tr>
<td><strong>Task</strong> 1 Develop Care transitions intervention model to include pre-discharge and post discharge patient contact, assessment and intervention.</td>
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<td><strong>Task</strong> 2 Develop pre-discharge plan template using evidence based standards in accordance with national standards</td>
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<td><strong>Task</strong> 3 Review pre-discharge plan requirements with partner hospitals and ensure that pre-discharge plans are standard and meet ACP's standards both in components and timing.</td>
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<td><strong>Task</strong> 4 Develop reporting methods for monitoring pre-discharge plans performed in the inpatient hospital setting.</td>
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<td><strong>Task</strong> 5 Convene Transitional Care project physician leads to draft, review and approve evidence based protocol for care transitions post discharge visit.</td>
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<td><strong>Task</strong> 6 Develop and implement standardized protocol for transitional care visits which include comprehensive medication reconciliation, assessments and interventions for conditions that have the highest incidence of hospital readmissions and the performance of which have proven to reduce re-hospitalizations such as fall risk assessments and implementing fall risk reduction plans amongst others. The protocol also calls for assessing patient's overall needs including social support referrals, DMEs, specialty services, home care, etc. for providing care for the patient in a team approach.</td>
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<td><strong>Task</strong> 7 Engage home care service agencies, social service agencies, home delivery services, and others as partners of the PPS to provide needed services to ACP patients. These agencies will serve on ACP's care Teams, PAC, Clinical Quality committees to assist the PPS in providing a team approach to patient care.</td>
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<td><strong>Task</strong> 8 Disseminate post discharge standardized protocol to ACP</td>
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| **Project Requirements**  
(Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
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<tr>
<td>providers using ACP's provider engagement teams, PAC, Care Teams, etc.</td>
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<td>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.</td>
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<td><strong>Task</strong> A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.</td>
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<td><strong>Task</strong> Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.</td>
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<td><strong>Task</strong> PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.</td>
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<td><strong>Task</strong> Disseminate care transitions protocols to MCOs and health homes working with ACP for the implementation.</td>
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<td><strong>Task</strong> Liaise and Coordinate between MCOs and Health Homes in the provision and coverage for services needed during the post discharge period.</td>
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<td><strong>Task</strong> Forge relationships with upper management at MCOs and Health Homes to bring appropriate level individuals to the negotiations table.</td>
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<tr>
<td><strong>Task</strong> Elaborate and Negotiate a payment strategy for transitional care visits including those done at PCP’s office and those done at the patient’s home as needed.</td>
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<tr>
<td><strong>Task</strong> Elaborate and negotiate a payment for services rendered in the Care Management and care coordination of transitional care services in coordination with the Health homes.</td>
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<tr>
<td><strong>Task</strong> Establish care coordination/back office team to receive feeds/reports from inpatient hospitals, MCOs and implement care coordination immediately to facilitate and ensure higher compliance rate and higher patient engagement rates.</td>
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<tr>
<td><strong>Task</strong> Establish Care Coordination processes and procedures indicating receipt of feed and processing of the information in a</td>
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<td>Project Requirements (Milestone/Task Name)</td>
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<tr>
<td>timely manner, attainment of pre-discharge plans, coordinating of care through social supports, specialty, home care, delivery and transitional care post discharge visits.</td>
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<tr>
<td>Task 8 Establish care Coordination platform, EMR, by which all data, patient information will be tracked.</td>
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<tr>
<td>Task 9 Establish clear lines of communication between ACP central care coordination and outreach and the Health Homes within the network.</td>
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<tr>
<td>Task 10 Develop and implement Health Home protocol that includes a clear definition of Health Home eligible and a clear process by which patient shall be linked to the Health Home.</td>
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<tr>
<td>Task 11 Train all care managers and care coordinators on Health Home eligibility and process for referring.</td>
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<tr>
<td>Task 12 Train all ACP providers on Health Home eligibility and process for referring.</td>
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<tr>
<td>Milestone #3 Ensure required social services participate in the project.</td>
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<tr>
<td>Task Required network social services, including medically tailored home food services, are provided in care transitions.</td>
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<tr>
<td>Task 1 Engage social service and social support entities in ACP's network.</td>
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<tr>
<td>Task 2 Incorporate social service and social support entities in ACP Care Teams and PAC. Social support services such as meal delivery services, God's Love we Deliver; Interim housing/shelters such as VIP are a part of ACP's network, Care Teams and PAC.</td>
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<tr>
<td>Milestone #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.</td>
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<tr>
<td>Task Policies and procedures are in place for early notification of planned discharges.</td>
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<tr>
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NYS Confidentiality – High
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<th>DY5,Q3</th>
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<td>Task Policies and procedures are in place for early notification of planned discharges.</td>
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<tr>
<td>Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.</td>
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<tr>
<td>Task ACP has worked with and negotiated with hospital partners and hospitals in other PPS, the hospitals will provide transition care managers and/or pre-discharge planners to develop and review discharge planning while the patient is still inpatient. The discharge plan and summary will be made available to the TC partner and to the PCP for more accurate and efficient treatment. The pre-discharge plan will also be used to coordinate needed services such as social support, home care, DME, etc. and the Transitional Care visit.</td>
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<tr>
<td>Task 1 Establish processes with partner hospitals in which a care transitions/pre-discharge plan nurse or care manager establishes the link with the patient and provides the pre-discharge plan at the patient's side, while the patient is still inpatient in accordance with the established transitional care protocol and standardized pre-discharge plan.</td>
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<tr>
<td>Task 2 Partner hospital will allow access to the patient to the care transition pre-discharge plan manager/nurse and in most cases the care manager/nurse will be a hospital staff member since ACP's partner hospitals have care transitions staff already on hand.</td>
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<tr>
<td>Task 3 Processes are in place to receive feeds from hospitals and MCOs on a daily basis of all admissions allowing for early notification of hospitalizations and thereby early access to patients for the provision of discharge planning.</td>
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<tr>
<td>Task 4 Processes and procedures are in place for prompt action upon receipt of the inpatient data feeds to begin the process of accessing the patient and implementing the plan.</td>
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<tr>
<td>Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.</td>
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<tr>
<td>Task Policies and procedures are in place for including care</td>
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### Project Requirements

<table>
<thead>
<tr>
<th>(Milestone/Task Name)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.</td>
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<tr>
<td><strong>Task 1</strong></td>
<td>Develop processes as mandated by protocol for transmission of Care transitions records to member's provider/PCP within 48 hours of Transitional Care visit.</td>
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<tr>
<td><strong>Task 2</strong></td>
<td>Utilizing guidelines from the National Transition of Care Coalition and working with the expertise of ACP partners who specialize in Care Transitions, ACP will bring together a standardized protocol/standard of care and processes for providing quality Care Transitions services. Protocol/Standard of Care to include comprehensive medication reconciliation, comprehensive evaluation, HEDIS assessments, ADL assessments, Fall risk, etc.</td>
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<tr>
<td><strong>Task 3</strong></td>
<td>Implement process as mandated by protocol by which member's provider/PCP receives Transitional Care visit records within 48 hours.</td>
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<tr>
<td><strong>Task 4</strong></td>
<td>Utilize EMR to transmit records to member's provider via P2P portal, FTP, HIE, RHIO or ACP platform to be created.</td>
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<tr>
<td><strong>Milestone #6</strong></td>
<td>Ensure that a 30-day transition of care period is established.</td>
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<tr>
<td><strong>Task</strong></td>
<td>Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.</td>
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<tr>
<td><strong>Task 1</strong></td>
<td>Implement care transition protocol mandate calculation of 30 day period to start on the date of discharge as day 0 and the day following discharge as day 1 up to 30 calendar days.</td>
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<tr>
<td><strong>Milestone #7</strong></td>
<td>Use EHRs and other technical platforms to track all patients engaged in the project.</td>
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<tr>
<td><strong>Task</strong></td>
<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<tr>
<td><strong>Task 1</strong></td>
<td>Processes are in place in which upon receipt of inpatient feeds, Care Transitions team ensures that all relevant patient data including diagnoses, demographics, etc. are entered into EMR.</td>
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<tr>
<td><strong>Task 2</strong></td>
<td>Utilizing Care transitions team's EMR structured fields all</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Advocate Community Providers, Inc. (PPS ID:25)

**Project Requirements (Milestone/Task Name)**

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
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<tbody>
<tr>
<td>3</td>
<td>Data mining from Care Transitions team’s EMR and additional electronic systems are used to provide stratification, target identification and outreach population wide, patient specific and overall tracking and reporting.</td>
</tr>
<tr>
<td>4</td>
<td>Additional data filters and repositories are created within hospital EMR, ACP central Care Coordination systems for redundancy, data verification and comparison analytics.</td>
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<table>
<thead>
<tr>
<th>Prescribed Milestones Current File Uploads</th>
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<tbody>
<tr>
<td>Milestone Name</td>
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<table>
<thead>
<tr>
<th>Prescribed Milestones Narrative Text</th>
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<tbody>
<tr>
<td>Milestone Name</td>
</tr>
<tr>
<td>Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Ensure required social services participate in the project.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Protocols will include care record transitions with timely updates provided to the members’ providers, particularly primary care provider.</td>
</tr>
</tbody>
</table>

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.

NYS Confidentiality – High
## Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>Ensure that a 30-day transition of care period is established.</td>
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</tr>
<tr>
<td>Use EHRs and other technical platforms to track all patients engaged in the project.</td>
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</table>
### IPQR Module 2.b.iv.5 - PPS Defined Milestones

**Instructions:**
Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRI Reporting Year and Quarter</th>
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### PPS Defined Milestones Current File Uploads

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### PPS Defined Milestones Narrative Text

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<th>Milestone Name</th>
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IPQR Module 2.b.iv.6 - IA Monitoring

Instructions:

Milestone 5: PPS may consider task of convening providers from different care settings to define specific information and clinical data between sending and receiving providers as patient goes from one care setting to another to include as part of care transition record. The National Transition of Care Coalition is a good resource. [http://www.ntocc.org/Toolbox/](http://www.ntocc.org/Toolbox/)
Project 3.a.i – Integration of primary care and behavioral health services

Instructions:

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Major risks for this project revolve around patient compliance as well as the stigma/taboo associated with mental illness. Patient engagement is predicated on PHQ9 scores; however, PHQ9 relies on patient's subjective responses to questions regarding their feeling depressed. It is hard in many cultures and specifically the cultures serviced by ACP PPS to admit to any form of mental issue as it is seen as a sign of weakness, a lack of faith or a make believe, self made up condition. The PPS plans to mitigate this through its fostering of a strong PCP/Patient relationship. The more that the patient trusts and believes in his/her PCP, the more prone the patient is to confide in the PCP. Because ACP's providers speak the same language and are of the same culture as the patients it is well positioned to have a strong, lasting relationship with its patients. ACP expects that all PHQ2's and PHQ9's will be faithfully and honestly completed by the patients.
### IPQR Module 3.a.i.2 - Project Implementation Speed

**Instructions:**

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.

Note: data entered into this table must represent CUMULATIVE figures.

#### Benchmarks

<table>
<thead>
<tr>
<th>100% Total Committed By</th>
<th>DY2,Q4</th>
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#### Year,Quarter (DY1,Q1 – DY3,Q2)

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<tr>
<td>Primary Care Physicians</td>
<td>902</td>
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<tr>
<td>Non-PCP Practitioners</td>
<td>1,428</td>
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<tr>
<td>Clinics</td>
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<tr>
<td>Behavioral Health</td>
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<td>All Other</td>
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<td>Percent Committed Providers (%)</td>
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#### Year,Quarter (DY3,Q3 – DY5,Q4)

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<td>43</td>
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<tr>
<td>Behavioral Health</td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>All Other</td>
<td>1,418</td>
<td>1,418</td>
</tr>
</tbody>
</table>
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Advocate Community Providers, Inc. (PPS ID:25)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY3,Q3</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>3,970</td>
<td>3,970</td>
</tr>
<tr>
<td>Percent Committed Providers(%)</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Current File Downloads

<table>
<thead>
<tr>
<th>User ID</th>
<th>File Name</th>
<th>File Description</th>
<th>Upload Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Narrative Text:

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
IPQR Module 3.a.i.3 - Patient Engagement Speed

Instructions:

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application. Note: data entered into this table must represent CUMULATIVE figures.

### Benchmarks

| Year,Quarter (DY1,Q1 – DY3,Q2) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
|--------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
|patients Engaged               | 0      | 53,836 | 96,905 | 139,973| 41,545 | 118,439| 145,357| 172,275| 48,991 | 139,973|      |
|Percent of Expected Patient Engagement(%) | 0.00   | 25.00  | 45.00  | 65.00  | 19.29  | 55.00  | 67.50  | 80.00  | 22.75  | 65.00  |      |

| Year,Quarter (DY3,Q3 – DY5,Q4) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4 |
|--------------------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------|
|patients Engaged               | 177,659| 215,344| 48,991 | 139,973| 177,659| 215,344| 48,994 | 139,973| 177,659| 215,344|      |
|Percent of Expected Patient Engagement(%) | 82.50  | 100.00 | 22.75  | 65.00  | 82.50  | 100.00 | 22.75  | 65.00  | 82.50  | 100.00 |      |

Current File Uploads

- User ID
- File Name
- File Description
- Upload Date

No Records Found

Narrative Text:

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
### IPQR Module 3.a.i.4 - Prescribed Milestones

Instructions:

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

<table>
<thead>
<tr>
<th>Milestone #1 (Milestone/Task Name)</th>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Model 1</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>Behavioral health services are co-located within PCMH/APC practices and are available.</td>
<td>Provider</td>
<td>Behavioral Health</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>1 Survey and group all participating providers (safety net and non safety net) into level of readiness.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>2 Develop plan, timelines, and assign resources for each level of readiness.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>3 Clinical governance committee approves partner assessment results and PCMH roadmap.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>5 Implement plan.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2017</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Milestone #2</strong> (Milestone/Task Name)</td>
<td>Model 1</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>Develop collaborative evidence-based standards of care including medication management and care engagement process.</td>
<td>Project</td>
<td></td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Regularly scheduled formal meetings are held to develop collaborative care practices.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task</strong></td>
</tr>
<tr>
<td><strong>Provider Type</strong></td>
</tr>
<tr>
<td><strong>Status</strong></td>
</tr>
<tr>
<td><strong>Start Date</strong></td>
</tr>
<tr>
<td><strong>End Date</strong></td>
</tr>
<tr>
<td><strong>Quarter End Date</strong></td>
</tr>
<tr>
<td><strong>DSRIP Reporting Year and Quarter</strong></td>
</tr>
</tbody>
</table>

| Task 1 | In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination. |
| --- |
| **Provider Type** | Project |
| **Status** | Completed |
| **Start Date** | 04/01/2015 |
| **End Date** | 06/30/2015 |
| **Quarter End Date** | 06/30/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q1 |

| Task 2 | Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices. |
| --- |
| **Provider Type** | Project |
| **Status** | In Progress |
| **Start Date** | 04/01/2015 |
| **End Date** | 12/31/2015 |
| **Quarter End Date** | 12/31/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q3 |

| Task 3 | Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc. |
| --- |
| **Provider Type** | Project |
| **Status** | In Progress |
| **Start Date** | 04/01/2015 |
| **End Date** | 12/31/2015 |
| **Quarter End Date** | 12/31/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q3 |

| Task 4 | Develop procedures to implement evidence based protocols with prescribed assessment tools including PHQ2/9, GAD, DAST, Audit C and SBIRT, stepped care, care team meetings, number of prescribers, etc. |
| --- |
| **Provider Type** | Project |
| **Status** | Completed |
| **Start Date** | 04/01/2015 |
| **End Date** | 06/30/2015 |
| **Quarter End Date** | 06/30/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q1 |

| Task 5 | Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers. |
| --- |
| **Provider Type** | Project |
| **Status** | In Progress |
| **Start Date** | 10/01/2015 |
| **End Date** | 06/30/2016 |
| **Quarter End Date** | 06/30/2016 |
| **DSRIP Reporting Year and Quarter** | DY2 Q1 |

| Task 6 | Establish Care teams within the practice to include care coordination to follow patients and provide "warm handoffs" |
| --- |
| **Provider Type** | Project |
| **Status** | In Progress |
| **Start Date** | 04/01/2015 |
| **End Date** | 09/30/2015 |
| **Quarter End Date** | 09/30/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q2 |

| Task 7 | Establish procedure for "warm handoffs" |
| --- |
| **Provider Type** | Project |
| **Status** | In Progress |
| **Start Date** | 10/01/2015 |
| **End Date** | 03/31/2016 |
| **Quarter End Date** | 03/31/2016 |
| **DSRIP Reporting Year and Quarter** | DY1 Q4 |

| Task 8 | In accordance with evidence based care protocols, implement process for medication prescribing and management. The process will delineate one prescriber process. |
| --- |
| **Provider Type** | Project |
| **Status** | In Progress |
| **Start Date** | 10/01/2015 |
| **End Date** | 03/31/2016 |
| **Quarter End Date** | 03/31/2016 |
| **DSRIP Reporting Year and Quarter** | DY1 Q4 |

| Task 9 | Develop processes and procedures for care coordinators and care managers to engage in patient treatment as per protocols. |
| --- |
| **Provider Type** | Project |
| **Status** | In Progress |
| **Start Date** | 10/01/2015 |
| **End Date** | 06/30/2016 |
| **Quarter End Date** | 06/30/2016 |
| **DSRIP Reporting Year and Quarter** | DY2 Q1 |
# Advocate Community Providers, Inc. (PPS ID:25)

## DSRIP Implementation Plan Project

<table>
<thead>
<tr>
<th>Milestone #3 (Milestone/Task Name)</th>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Model 1</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Policies and procedures are in place to facilitate and document completion of screenings.</td>
<td></td>
<td>Project</td>
<td></td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td>Screenings are documented in Electronic Health Record.</td>
<td></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
<td></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Positive screenings result in “warm transfer” to behavioral health provider as measured by documentation in Electronic Health Record.</td>
<td></td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td>1 Integrate assessment tools, PHQ2/9, DAST, Audit C and GAD into EMR for ease of access, and tracking and, monitoring</td>
<td></td>
<td>Project</td>
<td></td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td>2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, Audit C, DAST for all patients. Set as mandatory fields within EMR whenever possible.</td>
<td></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>3 Implement SBIRT as per established, implemented protocols.</td>
<td></td>
<td>Project</td>
<td></td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td>4 Create processes for referral and “warm handoffs”. Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for add -ins to schedule as necessary for “warm handoffs” from PCP</td>
<td></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>5 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of “warm handoff” as well as monitoring the hand off.</td>
<td></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>6 Allow creation within EMR of separate encounter for each</td>
<td></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
### Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
---|---|---|---|---|---|---|---|---
### Milestone #4
Use EHRs or other technical platforms to track all patients engaged in this project.

**Task**
- EHR demonstrates integration of medical and behavioral health record within individual patient records.

Milestone #5
Co-locate primary care services at behavioral health sites.

**Task**
- PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

**Task**
- 1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR.

**Task**
- 2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.

**Task**
- 3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.

**Task**
- 4 Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.

**Task**
- 5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP platforms, interfaces, and others.

**Milestone #5**
- Co-locate primary care services at behavioral health sites.

**Task**
- PPS has achieved NCQA 2014 Level 3 PCMH or Advanced

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NYS Confidentiality – High
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

Advocate Community Providers, Inc.  (PPS ID:25)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Model Practices by the end of DY3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care services are co-located within behavioral Health practices and are available.</td>
<td></td>
<td></td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care services are co-located within behavioral Health practices and are available.</td>
<td></td>
<td></td>
<td>Behavioral Health</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Provide office space and staff for provision of full primary care services</td>
<td></td>
<td></td>
<td></td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Contract with EMR to ensure functionality provides for scheduling for both provider types within the same EMR where patient has a single record.</td>
<td></td>
<td></td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Contract with EMR to add PCP licenses and templates for full documentation capabilities within the EMR and ensure a single repository of health information and data sharing amongst providers.</td>
<td></td>
<td></td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Partner with EMR vendor to ensure that security features are activated to ensure patient privacy and confidentiality of secure notes.</td>
<td></td>
<td></td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Ensure that confidentiality agreements are in place between providers for data use and exchange of information.</td>
<td></td>
<td></td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong></td>
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</tr>
<tr>
<td>6 Develop and implement processes for physical medicine assessments within the BH workflow to identify potential health problems and provide early intervention, disease prevention and higher quality of care for BH patients</td>
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<tr>
<td>Regularly scheduled formal meetings are held to develop collaborative care practices.</td>
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<tr>
<td>Coordinated evidence-based care protocols are in place, including</td>
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NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)  

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<td>a medication management and care engagement process.</td>
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<td>In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.</td>
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<td>Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices.</td>
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<td>Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc.</td>
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<td>Implement evidence based protocols with prescribed assessment tools, SBRIT, stepped care, care team meetings, number of prescribers, etc.</td>
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<tr>
<td>Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers.</td>
<td>Project</td>
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<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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<tr>
<td>Establish Care teams within the practice to include care coordination to follow patients and provide &quot;warm handoffs&quot;.</td>
<td>Project</td>
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<td>09/30/2015</td>
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<tr>
<td>Establish procedure for &quot;warm handoffs&quot;.</td>
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<td>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.</td>
<td>Model 2</td>
<td>Project</td>
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<td>12/31/2016</td>
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<tr>
<td>Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
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<tr>
<td>Screenings are documented in Electronic Health Record.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
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<tr>
<td>At least 90% of patients receive screenings at the established</td>
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<td>04/01/2015</td>
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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
<td>project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>12/31/2016</td>
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<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> Positive screenings result in “warm transfer” to behavioral health provider as measured by documentation in Electronic Health Record.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>10/01/2015</td>
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<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td><strong>Task</strong> 1 Integrate assessment tools, PHQ2/9, DAST and GAD into EMR for ease of access and tracking, monitoring.</td>
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<tr>
<td><strong>Task</strong> 2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, DAST for all patients. Set mandatory fields within EMR whenever possible.</td>
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<tr>
<td><strong>Task</strong> 3 Implement SBIRT as per established, implemented protocols</td>
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<tr>
<td><strong>Task</strong> 4 Define protocols for screening for physical illness. Screenings to include illnesses such as Diabetes, Cardiovascular disease, Cancer screenings, etc. as well as implement other illness preventions such as immunizations.</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
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<td>06/30/2015</td>
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<tr>
<td><strong>Task</strong> 5 Create processes for “warm handoffs”. Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for ad ins to schedule as necessary for PCP “warm handoffs”</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
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<td>03/31/2016</td>
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</tr>
<tr>
<td><strong>Task</strong> 6 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of “warm handoff” as well as monitoring the hand off.</td>
<td>Project</td>
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<td>10/01/2015</td>
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<tr>
<td><strong>Task</strong> 7 Allow creation within EMR of separate encounter for each provider, PCP and BH, on the same day within single patient record and single billing claim record.</td>
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<tr>
<td><strong>Milestone #8</strong> Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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NYS Confidentiality – High
## Project Requirements

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<tr>
<td>EHR demonstrates integration of medical and behavioral health record within individual patient records.</td>
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<tr>
<td><strong>Task</strong> PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<tr>
<td><strong>Task</strong> 1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR</td>
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<td>03/31/2016</td>
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<tr>
<td><strong>Task</strong> 2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.</td>
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<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td><strong>Task</strong> 3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.</td>
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<td>03/31/2016</td>
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<td><strong>Task</strong> 4 Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.</td>
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<tr>
<td><strong>Task</strong> 5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP platforms, interfaces, and others</td>
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**Milestone #9** Implement IMPACT Model at Primary Care Sites.

| Model 3 | Project | N/A                  | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4   |                                |

**Task** PPS has implemented IMPACT Model at Primary Care Sites.

| Provider | Primary Care Physicians | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4   |                                |

**Task** 1 In conjunction with physician leads and in accordance with SAHMSA guidelines develop evidence based protocols for the evaluation and treatment of Behavioral health conditions by the Primary care Provider consistent with IMPACT model of integrated care. Protocol also includes GAD, DAST, Audit C assessments.

| Project | Completed | 04/01/2015 | 06/30/2015 | 06/30/2015 | DY1 Q1   |                                |
## Project Requirements
(Milestone/Task Name)

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<th>Quarter End Date</th>
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<td>2</td>
<td>Deploy physician engagement team to PCP practices to engage PCPs, distribute and train on evidence based protocol and secure commitment of PCP in the implementation of IMPACT.</td>
<td>Project</td>
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<td>3</td>
<td>Through Physician engagement meetings provide a forum for PCPs to learn about IMPACT, receive protocols and review processes.</td>
<td>Project</td>
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<td>06/30/2015</td>
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<td>4</td>
<td>Incorporate assessment tools, PHQ2/9, GAD, Audit C and DAST into practice EMR.</td>
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<td>5</td>
<td>Employ assessment tools in EMR on all patients at PCP visits and SBIRT to identify patients in need of care early and provide intervention.</td>
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<td>6</td>
<td>Hire and train Depression care managers to provide services consistent with IMPACT model of care at PCP sites.</td>
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<td>7</td>
<td>Develop and implement process and procedures for assigning Care managers.</td>
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<td>8</td>
<td>Develop and implement processes and timelines by which Depression care manager will engage, evaluate and implement treatment plan with patient</td>
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<td>9</td>
<td>Develop communications process between Depression care Manager and PCP.</td>
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<td>10</td>
<td>Develop communications process between Depression Care manager and supervising psychiatrist.</td>
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<td>11</td>
<td>Develop and implement process by which Depression care manager will document follow ups and patient encounters, treatment adjustments and/or compliance within the PCP’s EMR.</td>
<td>Project</td>
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<td>12</td>
<td>Develop processes to connect with the different provider types within the ACP Care Teams to provide complete care to patients</td>
<td>Project</td>
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<td>10/01/2015</td>
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<th>End Date</th>
<th>Quarter End Date</th>
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</thead>
<tbody>
<tr>
<td>For all aspects of care. These processes shall include Integrated Delivery System and the use of the ACP care managers and care coordinators to monitor referrals, services and ensure timely delivery of services to patients.</td>
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<td>Milestone #10</td>
<td>Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.</td>
<td>Model 3</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
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<td>Task</td>
<td>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.</td>
<td>Project</td>
<td>Completed</td>
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<td>Task</td>
<td>Policies and procedures include process for consulting with Psychiatrist.</td>
<td>Project</td>
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<tr>
<td>Task</td>
<td>1 Develop processes to implement collaborative care standards as required in ACP evidence based protocols.</td>
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<td>Task</td>
<td>2 Create policies and procedures for engaging patients and assigning care team member, depression Care manager.</td>
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<td>Task</td>
<td>3 Create processes per evidence based protocols for implementation of care including single prescriber, stepped care consistent with IMPACT model.</td>
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<td>Task</td>
<td>4 Hire, train and deploy Depression care managers to provide care for engaged patients in collaboration with PCP and IMPACT model.</td>
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<td>Task</td>
<td>5 Develop processes for creating a secure data repository to be accessed by supervising psychiatrist for monitoring and evaluation of the efficacy of care in accordance with IMPACT model.</td>
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<td>6 Develop process for assigning supervising psychiatrist.</td>
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<td>Task</td>
<td>7 Establish care team meeting schedules for review of treatment plans with Care managers and PCPs as well as care coordinators as needed.</td>
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Advocate Community Providers, Inc. (PPS ID:25)

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NYS Confidentiality – High
# Project Requirements

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<tr>
<td>Task 4</td>
<td>Develop programs for continuing education for depression care managers to assist in providing and maintaining high standards of care to patients in implementation of care and treatment plans.</td>
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<td>Task 5</td>
<td>Develop training manuals for depression care manager on EMRs used at PCP practices for documentation of all services and assessments within the single EMR. Training will be concise and focused on documenting all encounters, assessments and treatment plans in a format amenable to extracting data for metrics and performance reporting.</td>
<td>Project</td>
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<td>Task 6</td>
<td>Develop depression care manager roles and responsibilities to include all services to be provided to patient in accordance with IMPACT model care guidelines.</td>
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<tr>
<td>Milestone #12</td>
<td>Designate a Psychiatrist meeting requirements of the IMPACT Model.</td>
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<td>Task</td>
<td>All IMPACT participants in PPS have a designated Psychiatrist.</td>
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<tr>
<td>Task 1</td>
<td>Engage psychiatrists and establish service agreements with ACP network psychiatrists to provide supervision of treatment plans and assessments consistent with the IMPACT model such as with Dr. Fernando Taveras and Dr. Rodney Campos, amongst others.</td>
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<tr>
<td>Task 2</td>
<td>Create a secure site for repository of information to be accessed by psychiatrists. Site will hold treatment and assessment note on patients engaged in the IMPACT model which will be evaluated by supervising psychiatrist assigned to the patient.</td>
<td>Project</td>
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<td>12/31/2015</td>
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<tr>
<td>Task 3</td>
<td>Develop a process for assigning patients to designated psychiatrist. Designations will be based primarily on patient’s language, culture and relationship with the PCP and the community being served. This criteria will allow for a greater understanding of the patient’s social conditions as well as a greater chance of compliance if psychiatrist face to face consult is required at a later time.</td>
<td>Project</td>
<td>In Progress</td>
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NYS Confidentiality – High
### Advocate Community Providers, Inc. (PPS ID: 25)

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<th>Quarter End Date</th>
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<tbody>
<tr>
<td>4 Develop process by which Depression Care manager uploads patient information into Psychiatrist's secure site.</td>
<td>Model 3</td>
<td>Project</td>
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<tr>
<td><strong>Milestone #13</strong> Measure outcomes as required in the IMPACT Model.</td>
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<tr>
<td>1 At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
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<tr>
<td>2 Incorporate assessment tools, ie. PHQ9 into PCP’s EMR</td>
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<td>3 Implement procedures for periodic repeat assessments in accordance with stepped care prescribed in evidence based protocol performed by the Depression care manager within the PCP’s EMR.</td>
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<tr>
<td>4 Use PCP’s EMR to extrapolate comparison data, flow sheets to establish trends in symptoms based on assessment responses and measure outcomes.</td>
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<td><strong>Milestone #14</strong> Provide &quot;stepped care&quot; as required by the IMPACT Model.</td>
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<tr>
<td>1 In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.</td>
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<tr>
<td>2 Process is created for assignment of patient to Depression care manager for continuity of care and monitoring.</td>
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<td>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</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

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<td>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.</td>
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<td>Behavioral health services are co-located within PCMH/APC practices and are available.</td>
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<td>1 Survey and group all participating providers (safety net and non safety net) into level of readiness.</td>
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<td>2 Develop plan, timelines, and assign resources for each level of readiness.</td>
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<td>3 Clinical governance committee approves partner assessment results and PCMH roadmap.</td>
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<td>4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).</td>
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<td>5 Implement plan.</td>
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<tr>
<td>6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.</td>
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**Milestone #2**

Develop collaborative evidence-based standards of care including medication management and care engagement process.

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<tbody>
<tr>
<td>In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.</td>
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<td>Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices.</td>
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## Project Requirements (Milestone/Task Name)

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<td>3</td>
<td>Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc.</td>
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<td>4</td>
<td>Develop procedures to implement evidence based protocols with prescribed assessment tools including PHQ2/9, GAD, DAST, Audit C and SBIRT, stepped care, care team meetings, number of prescribers, etc.</td>
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<tr>
<td>5</td>
<td>Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers.</td>
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<td>6</td>
<td>Establish Care teams within the practice to include care coordination to follow patients and provide “warm handoffs”</td>
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<td>7</td>
<td>Establish procedure for “warm handoffs”</td>
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<td>8</td>
<td>In accordance with evidence based care protocols, implement process for medication prescribing and management. The process will delineate one prescriber process.</td>
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<td>9</td>
<td>Develop processes and procedures for care coordinators and care managers to engage in patient treatment as per protocols.</td>
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<td>Milestone #3</td>
<td>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.</td>
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<td>Task</td>
<td>Policies and procedures are in place to facilitate and document completion of screenings.</td>
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<td>Task</td>
<td>Screenings are documented in Electronic Health Record.</td>
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<td>Task</td>
<td>At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
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<td>Task</td>
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NYS Confidentiality – High
# Project Requirements

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<tr>
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<td><strong>Task</strong> 2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, Audit C, DAST for all patients. Set as mandatory fields within EMR whenever possible.</td>
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<td><strong>Task</strong> 3 Implement SBIRT as per established, implemented protocols.</td>
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<td><strong>Task</strong> 4 Create processes for referral and &quot;warm handoffs&quot;. Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for add -ins to schedule as necessary for &quot;warm handoffs&quot; from PCP</td>
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<td><strong>Task</strong> 5 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of &quot;warm handoff&quot; as well as monitoring the hand off.</td>
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**Milestone #4**

Use EHRs or other technical platforms to track all patients engaged in this project.

**Task**

EHR demonstrates integration of medical and behavioral health record within individual patient records.

**Task**

PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

**Task**

1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR.

**Task**

2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.

**Task**

3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and

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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Advocate Community Providers, Inc.  (PPS ID:25)

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<td>accessible to treating providers to increase efficiency and decrease duplication and error.</td>
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<td>Task 5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP platforms, interfaces, and others.</td>
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<td>Milestone #5 Co-locate primary care services at behavioral health sites.</td>
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<td>Task 1 Provide office space and staff for provision of full primary care services</td>
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<td>Task 2 Contract with EMR to ensure functionality provides for scheduling for both provider types within the same EMR where patient has a single record.</td>
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<td>Task 3 Contract with EMR to add PCP licenses and templates for full documentation capabilities within the EMR and ensure a single repository of health information and data sharing amongst providers.</td>
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<td>Task 4 Partner with EMR vendor to ensure that security features are activated to ensure patient privacy and confidentiality of secure notes.</td>
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<td>Task 5 Ensure that confidentiality agreements are in place between providers for data use and exchange of information.</td>
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<td>Task 6 Develop and implement processes for physical medicine assessments within the BH workflow to identify potential health</td>
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### Project Requirements

(Results/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2 |
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
problems and provide early intervention, disease prevention and higher quality of care for BH patients  
Milestone #6  
Develop collaborative evidence-based standards of care including medication management and care engagement process.  
Task  
Regularly scheduled formal meetings are held to develop collaborative care practices.  
Task  
Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.  
Task  
1 In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.  
Task  
2 Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices.  
Task  
3 Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc.  
Task  
4 Implement evidence based protocols with prescribed assessment tools, SBRIT, stepped care, care team meetings, number of prescribers, etc.  
Task  
5 Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers.  
Task  
6 Establish Care teams within the practice to include care coordination to follow patients and provide "warm handoffs"  
Task  
7 Establish procedure for “warm handoffs”.  
Milestone #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.  
Task  
Screenings are conducted for all patients. Process workflows
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
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<td>and operational protocols are in place to implement and document screenings.</td>
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<td>Task 3 Implement SBRIT as per established, implemented protocols</td>
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<td>Task 4 Define protocols for screening for physical illness. Screenings to include illnesses such as Diabetes, Cardiovascular disease, Cancer screenings, etc. as well as implement other illness prevention such as immunizations.</td>
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<td>Milestone #9 Implement IMPACT Model at Primary Care Sites.</td>
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<tr>
<td>Task 1 In conjunction with physician leads and in accordance with SAHMSA guidelines develop evidence based protocols for the evaluation and treatment of Behavioral health conditions by the Primary cAre Provider consistent with IMPACT model of integrated care. Protocol also includes GAD, DAST, Audit C assessments and includes SBIRT, stepped care and quadrant clinical care.</td>
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<td>Task 2 Deploy physician engagement team to PCP practices to engage PCPs, distribute and train on evidence based protocol</td>
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and secure commitment of PCP in the implementation of IMPACT.

**Task**
3 Through Physician engagement meetings provide a forum for PCPs to learn about IMPACT, receive protocols and review processes.

**Task**
4 Incorporate assessment tools, PHQ2/9, GAD, Audit C and DAST into practice EMR.

**Task**
5 Employ assessment tools in EMR on all patients at PCP visits and SBIRT to identify patients in need of care early and provide intervention.

**Task**
6 Hire and train Depression care managers to provide services consistent with IMPACT model of care at PCP sites.

**Task**
7 Develop and implement process and procedures for assigning Care managers.

**Task**
8 Develop and implement processes and timelines by which Depression care manager will engage, evaluate and implement treatment plan with patient.

**Task**
9 Develop communications process between Depression care Manager and PCP.

**Task**
10 Develop communications process between Depression Care manager and supervising psychiatrist.

**Task**
11 Develop and implement process by which Depression care manager will document follow ups and patient encounters, treatment adjustments and/or compliance within the PCP’s EMR.

**Task**
12 Develop processes to connect with the different provider types within the ACP Care Teams to provide complete care to patients for all aspects of care. These processes shall include Integrated Delivery System and the use of the ACP care managers and care coordinators to monitor referrals, services and ensure timely delivery of services to patients.

**Milestone #10**
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.
## Project Requirements

<table>
<thead>
<tr>
<th>Task</th>
<th>Project Requirements (Milestone/Task Name)</th>
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</thead>
<tbody>
<tr>
<td><strong>DY1,Q1</strong></td>
<td>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.</td>
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<tr>
<td><strong>DY1,Q2</strong></td>
<td>Policies and procedures include process for consulting with Psychiatrist.</td>
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<tr>
<td><strong>DY1,Q3</strong></td>
<td>1 Develop processes to implement collaborative care standards as required in ACP evidence based protocols.</td>
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<tr>
<td><strong>DY1,Q4</strong></td>
<td>2 Create policies and procedures for engaging patients and assigning care team member, depression Care manager.</td>
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<tr>
<td><strong>DY2,Q1</strong></td>
<td>3 Create processes per evidence based protocols for implementation of care including single prescriber, stepped care consistent with IMPACT model.</td>
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<tr>
<td><strong>DY2,Q2</strong></td>
<td>4 Hire, train and deploy Depression care managers to provide care for engaged patients in collaboration with PCP and IMPACT model.</td>
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<tr>
<td><strong>DY2,Q3</strong></td>
<td>5 Develop processes for creating a secure data repository to be accessed by supervising psychiatrist for monitoring and evaluation of the efficacy of care in accordance with IMPACT model.</td>
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<tr>
<td><strong>DY2,Q4</strong></td>
<td>6 Develop process for assigning supervising psychiatrist.</td>
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<tr>
<td><strong>DY3,Q1</strong></td>
<td>7 Establish care team meeting schedules for review of treatment plans with Care managers and PCPs as well as care coordinators as needed.</td>
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<tr>
<td><strong>DY3,Q2</strong></td>
<td>8 Establish processes for continuous open lines of communication between PCP and care manager.</td>
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<tr>
<td><strong>DY3,Q3</strong></td>
<td>9 Establish clear process per evidence based protocol for consulting with Psychiatrist. When consult from psychiatrist is required and completed, psychiatrist will provide treatment recommendations and the single prescriber will remain the PCP in order to maintain the integrity of the IMPACT model.</td>
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<tr>
<td><strong>DY3,Q4</strong></td>
<td>Milestone #11: Employ a trained Depression Care Manager meeting requirements of the IMPACT model.</td>
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NYS Confidentiality – High
## Project Requirements

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<th>Task Description</th>
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<td>PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.</td>
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<td>Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.</td>
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<td>1 ACP will hire and deploy depression care managers in accordance with the IMPACT model. The Depression Care manager will assist the PCP in implementing treatment plans, counseling and will monitor progress, medication refills and adjustment as adjusted by the prescribing provider.</td>
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<td>2 Develop process and procedures for Depression care manager to access and work with Care coordinators to coordinate services for patients including social supports, home care, specialty services, etc.</td>
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<td>3 Develop ACP Care Manager training materials to Educate and train depression Care managers on ACP’s referral processes and network Regional Care team providers, level of services available and accessibility to ensure that Care managers are familiar with ACP partners and their services in order to provide patients timely and efficient access to care.</td>
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<td>4 Develop programs for continuing education for depression care managers to assist in providing and maintaining high standards of care to patients in implementation of care and treatment plans.</td>
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<td>5 Develop training manuals for depression care manager on EMRs used at PCP practices for documentation of all services and assessments within the single EMR. Training will be concise and focused on documenting all encounters, assessments and treatment plans in a format amenable to extracting data for metrics and performance reporting.</td>
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<td>6 Develop depression care manager roles and responsibilities to include all services to be provided to patient in accordance with IMPACT model care guidelines.</td>
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<td>the extrapolating of assessment data.</td>
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NYS Confidentiality – High
# Project Requirements

<table>
<thead>
<tr>
<th>Task</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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</thead>
<tbody>
<tr>
<td>rely on reportable data from MU dashboards, PCMH data fields, patient registries and others.</td>
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<tr>
<td><strong>Task</strong> 4 Use PCP's EMR to extrapolate comparison data, flow sheets to establish trends in symptoms based on assessment responses and measure outcomes.</td>
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<td><strong>Milestone #14</strong> Provide &quot;stepped care&quot; as required by the IMPACT Model.</td>
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<tr>
<td><strong>Task</strong> In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.</td>
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<tr>
<td><strong>Task</strong> 1 Implement Stepped care in accordance with ACP evidence based protocol, patients with positive PHQ9 values requiring treatment shall be treated as per specified treatment options and in stepped care by the PCP.</td>
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<td><strong>Task</strong> 2 Process is created for assignment of patient to Depression care manager for continuity of care and monitoring.</td>
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<tr>
<td><strong>Task</strong> 3 Process is created for continuous open lines of communication between Depression care manager and PCP, and on site care team as necessary.</td>
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<tr>
<td><strong>Task</strong> 4 In line with stepped care, Depression Care manager performs follow up PHQ9 assessment in intervals to ascertain effectiveness of treatment and make appropriate adjustments after consulting with PCP.</td>
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<td><strong>Milestone #15</strong> Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<tr>
<td><strong>Task</strong> EHR demonstrates integration of medical and behavioral health record within individual patient records.</td>
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<td><strong>Task</strong> PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td><strong>Task</strong> 1 Working with EMR vendors, assessment tools are incorporated within EMRs in a format that is reportable in which data is ascertainable.</td>
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<tr>
<td><strong>Task</strong> 2 Develop process for extrapolating and reporting data to track and monitor all engaged patients.</td>
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### Project Requirements (Milestone/Task Name)

<table>
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<th>DY4,Q4</th>
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<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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</thead>
<tbody>
<tr>
<td>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.</td>
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<td>1 Survey and group all participating providers (safety net and non safety net) into level of readiness.</td>
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<tr>
<td>2 Develop plan, timelines, and assign resources for each level of readiness.</td>
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<td>3 Clinical governance committee approves partner assessment results and PCMH roadmap.</td>
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<td>4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).</td>
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<td>5 Implement plan.</td>
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<td>6 Monitor weekly, monthly, quarterly progress against PCMH/EHR-MU work plan goals.</td>
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### Milestone #2

Develop collaborative evidence-based standards of care including medication management and care engagement.
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<th>DY5,Q2</th>
<th>DY5,Q3</th>
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<tr>
<td>Regularly scheduled formal meetings are held to develop</td>
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<td>collaborative care practices.</td>
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<td>Coordinated evidence-based care protocols are in place, including</td>
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<td>medication management and care engagement processes.</td>
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<td>1 In conjunction with physician leads, Develop evidence based</td>
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<td>protocols in accordance with SAHMSA guidelines which include</td>
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<td>assessment tools to be implemented, medication management,</td>
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<td>and care coordination.</td>
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<td>2 Establish formal meeting schedules amongst collaborating</td>
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<td>partners to establish collaborative care and best practices.</td>
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<td>3 Determine who needs to attend formal meetings - BH specialists,</td>
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<td>Primary Care, Substance Use Disorder,</td>
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<td>Developmentally Disabled providers, etc.</td>
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<td>4 Develop procedures to implement evidence based protocols with</td>
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<td>prescribed assessment tools including PHQ2/9, GAD, DAST, Audit C and</td>
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<td>SBIRT, stepped care, care team meetings, number of prescribers, etc.</td>
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<td>5 Develop monitoring parameters to evaluate adherence to evidence</td>
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<td>based protocols. These will include metrics showing use of</td>
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<td>assessment tools, medications prescribed, referrals</td>
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<td>made and number of prescribers.</td>
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<td>6 Establish Care teams within the practice to include care</td>
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<td>coordination to follow patients and provide &quot;warm handoffs&quot;</td>
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<td>7 Establish procedure for &quot;warm handoffs&quot;</td>
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<td>8 In accordance with evidence based care protocols, implement</td>
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<td>process for medication prescribing and management. The process will</td>
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<td>delineate one prescriber process.</td>
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<td>9 Develop processes and procedures for care coordinators and</td>
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<td>care managers to engage in patient treatment as per protocols.</td>
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<td>Conduct preventive care screenings, including behavioral</td>
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### Milestone #3

Conduct preventive care screenings, including behavioral

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NYS Confidentiality – High
## Project Requirements

### (Milestone/Task Name)

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<th>Dy4,Q4</th>
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<th>Dy5,Q2</th>
<th>Dy5,Q3</th>
<th>Dy5,Q4</th>
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</thead>
<tbody>
<tr>
<td>health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.</td>
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<td>Task</td>
<td>Policies and procedures are in place to facilitate and document completion of screenings.</td>
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<tr>
<td>Task</td>
<td>Screenings are documented in Electronic Health Record.</td>
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<td>Task</td>
<td>At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
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<td>Task</td>
<td>Positive screenings result in &quot;warm transfer&quot; to behavioral health provider as measured by documentation in Electronic Health Record.</td>
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<td>Task</td>
<td>1 Integrate assessment tools, PHQ2/9, DAST, Audit C and GAD into EMR for ease of access, and tracking and, monitoring</td>
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<td>Task</td>
<td>2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, Audit C, DAST for all patients. Set as mandatory fields within EMR whenever possible.</td>
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<td>Task</td>
<td>3 Implement SBIRT as per established, implemented protocols.</td>
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<td>Task</td>
<td>4 Create processes for referral and &quot;warm handoffs&quot;. Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for add-ins to schedule as necessary for &quot;warm handoffs&quot; from PCP</td>
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<td>Task</td>
<td>5 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of &quot;warm handoff&quot; as well as monitoring the hand off.</td>
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<td>Task</td>
<td>6 Allow creation within EMR of separate encounter for each provider, PCP and BH, on the same day within single patient record and single billing claim record.</td>
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### Milestone #4

Use EHRs or other technical platforms to track all patients engaged in this project.

### Task

EHR demonstrates integration of medical and behavioral health
### Project Requirements

<table>
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<th>DY3,Q4</th>
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<th>DY5,Q2</th>
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<tbody>
<tr>
<td>record within individual patient records.</td>
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<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td>1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR.</td>
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<td>2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.</td>
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<td>3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.</td>
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<td>4 Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.</td>
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<td>5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP platforms, interfaces, and others.</td>
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<td>PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.</td>
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<td>1 Provide office space and staff for provision of full primary care services</td>
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<td>2 Contract with EMR to ensure functionality provides for</td>
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## Project Requirements

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<th>(Milestone/Task Name)</th>
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<td><strong>scheduling for both provider types within the same EMR where patient has a single record.</strong></td>
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<td><strong>Task 3</strong> Contract with EMR to add PCP licenses and templates for full documentation capabilities within the EMR and ensure a single repository of health information and data sharing amongst providers.</td>
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<td><strong>Task 4</strong> Partner with EMR vendor to ensure that security features are activated to ensure patient privacy and confidentiality of secure notes.</td>
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<td><strong>Task 5</strong> Ensure that confidentiality agreements are in place between providers for data use and exchange of information.</td>
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<td><strong>Task 6</strong> Develop and implement processes for physical medicine assessments within the BH workflow to identify potential health problems and provide early intervention, disease prevention and higher quality of care for BH patients</td>
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<td><strong>Milestone #6</strong> Develop collaborative evidence-based standards of care including medication management and care engagement process.</td>
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<td><strong>Task</strong> Regularly scheduled formal meetings are held to develop collaborative care practices.</td>
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<td><strong>Task</strong> Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.</td>
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<td><strong>Task</strong> In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.</td>
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<td><strong>Task</strong> Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices.</td>
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<td><strong>Task</strong> Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc.</td>
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<td><strong>Task</strong> Implement evidence based protocols with prescribed assessment tools, SBIRT, stepped care, care team meetings.</td>
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### Project Requirements (Milestone/Task Name)

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<td>5 Develop monitoring parameters to evaluate adherence to evidence</td>
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<td>based protocols. These will include metrics showing use of</td>
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<td>7 Establish procedure for &quot;warm handoffs&quot;.</td>
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<td>Milestone #7</td>
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<td>Conduct preventive care screenings, including behavioral health</td>
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<td>Screenings are conducted for all patients. Process workflows</td>
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<td>Screenings are documented in Electronic Health Record.</td>
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<td>Positive screenings result in &quot;warm transfer&quot; to behavioral</td>
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<td>health provider as measured by documentation in Electronic Health</td>
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<td>1 Integrate assessment tools, PHQ2/9, DAST and GAD into EMR for</td>
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<td>ease of access and tracking, monitoring.</td>
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| 2 Create automation within EMR to prompt completion of assessments,
| PHQ2/9, GAD, DAST for all patients. Set mandatory fields within    |
| EMR whenever possible.                                             |
|                                                                   |
| Task                                                                |
| 3 Implement SBIRT as per established, implemented protocols        |
|                                                                   |
| Task                                                                |
| 4 Define protocols for screening for physical illness. Screenings  |
| to include illnesses such as Diabetes, Cardiovascular disease,     |
| Cancer screenings, etc. as well as implement other illness         |
| prevention such as immunizations.                                  |

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| 2 Create automation within EMR to prompt completion of assessments,
| PHQ2/9, GAD, DAST for all patients. Set mandatory fields within    |
| EMR whenever possible.                                             |
|                                                                   |
| Task                                                                |
| 3 Implement SBIRT as per established, implemented protocols        |
|                                                                   |
| Task                                                                |
| 4 Define protocols for screening for physical illness. Screenings  |
| to include illnesses such as Diabetes, Cardiovascular disease,     |
| Cancer screenings, etc. as well as implement other illness         |
| prevention such as immunizations.                                  |

NYS Confidentiality – High
## Project Requirements (Milestone/Task Name) | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4
---|---|---|---|---|---|---|---|---|---
**Task**<br>5 Create processes for “warm handoffs”. Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for ad ins to schedule as necessary for PCP “warm handoffs”<br><br>**Task**<br>6 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of “warm handoff” as well as monitoring the hand off.<br><br>**Task**<br>7 Allow creation within EMR of separate encounter for each provider, PCP and BH, on the same day within single patient record and single billing claim record.<br><br>**Milestone #8**<br>Use EHRs or other technical platforms to track all patients engaged in this project.<br><br>**Task**<br>EHR demonstrates integration of medical and behavioral health record within individual patient records.<br><br>**Task**<br>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.<br><br>**Task**<br>Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR.<br><br>**Task**<br>Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.<br><br>**Task**<br>Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.<br><br>**Task**<br>Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.<br><br>**Task**<br>Develop processes to generate reports showing assessment results to compare and track actively engaged patient.<br><br>NYS Confidentiality – High
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<td>5 Employ assessment tools in EMR on all patients at PCP visits</td>
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<td>6 Hire and train Depression care managers to provide services</td>
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<td>8 Develop and implement processes and timelines by which</td>
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<td>9 Develop communications process between Depression care</td>
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<td>10 Develop communications process between Depression Care manager and supervising psychiatrist.</td>
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<td>11 Develop and implement process by which Depression care manager will document follow ups and patient encounters, treatment adjustments and/or compliance within the PCP’s EMR.</td>
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<td>12 Develop processes to connect with the different provider types within the ACP Care Teams to provide complete care to patients for all aspects of care. These processes shall include Integrated Delivery System and the use of the ACP care managers and care coordinators to monitor referrals, services and ensure timely delivery of services to patients.</td>
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<td>Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.</td>
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<td>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.</td>
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<td>3 Create processes per evidence based protocols for implementation of care including single prescriber, stepped care consistent with IMPACT model.</td>
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<td>5 Develop processes for creating a secure data repository to be accessed by supervising psychiatrist for monitoring and evaluation of the efficacy of care in accordance with IMPACT</td>
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<td>Develop process for assigning supervising psychiatrist.</td>
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<td>Establish care team meeting schedules for review of treatment plans with Care managers and PCPs as well as care coordinators as needed.</td>
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<td>Establish processes for continuous open lines of communication between PCP and care manager.</td>
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<td>Establish clear process per evidence based protocol for consulting with Psychiatrist. When consult from psychiatrist is required and completed, psychiatrist will provide treatment recommendations and the single prescriber will remain the PCP in order to maintain the integrity of the IMPACT model.</td>
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<td>Employ a trained Depression Care Manager meeting requirements of the IMPACT model.</td>
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<td>PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.</td>
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<td>Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.</td>
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<td>ACP will hire and deploy depression care managers in accordance with the IMPACT model. The Depression Care manager will assist the PCP in implementing treatment plans, counseling and will monitor progress, medication refills and adjustment as adjusted by the prescribing provider.</td>
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<td>Develop process and procedures for Depression care manager to access and work with Care coordinators to coordinate services for patients including social supports, home care, specialty services, etc.</td>
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<td>Develop ACP Care Manager training materials to Educate and train depression Care managers on ACP's referral processes and network Regional Care team providers, level of</td>
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## Project Requirements

**Task 4** Develop programs for continuing education for depression care managers to assist in providing and maintaining high standards of care to patients in implementation of care and treatment plans.

**Task 5** Develop training manuals for depression care manager on EMRs used at PCP practices for documentation of all services and assessments within the single EMR. Training will be concise and focused on documenting all encounters, assessments and treatment plans in a format amenable to extracting data for metrics and performance reporting.

**Task 6** Develop depression care manager roles and responsibilities to include all services to be provided to patient in accordance with IMPACT model care guidelines.

**Milestone #12**

- Designate a Psychiatrist meeting requirements of the IMPACT Model.

**Task**

- All IMPACT participants in PPS have a designated Psychiatrist.

**Task**

1. Engage psychiatrists and establish service agreements with ACP network psychiatrists to provide supervision of treatment plans and assessments consistent with the IMPACT model such as with Dr. Fernando Taveras and Dr. Rodney Campos, amongst others.

**Task**

2. Create a secure site for repository of information to be accessed by psychiatrists. Site will hold treatment and assessment note on patients engaged in the IMPACT model which will be evaluated by supervising psychiatrist assigned to the patient.

**Task**

3. Develop a process for assigning patients to designated psychiatrist. Designations will be based primarily on patient's language, culture and relationship with the PCP and the community being served. This criteria will allow for a greater understanding of the patient's social conditions as well as a greater chance of compliance if psychiatrist face to face consult is required at a later time.

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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY3,Q3</th>
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<th>DY5,Q2</th>
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<tr>
<td>services available and accessibility to ensure that Care managers are familiar with ACP partners and their services in order to provide patients timely and efficient access to care.</td>
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<td>5 Develop training manuals for depression care manager on EMRs used at PCP practices for documentation of all services and assessments within the single EMR. Training will be concise and focused on documenting all encounters, assessments and treatment plans in a format amenable to extracting data for metrics and performance reporting.</td>
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<td>6 Develop depression care manager roles and responsibilities to include all services to be provided to patient in accordance with IMPACT model care guidelines.</td>
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<td>Designate a Psychiatrist meeting requirements of the IMPACT Model.</td>
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<td>All IMPACT participants in PPS have a designated Psychiatrist.</td>
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<td>2 Create a secure site for repository of information to be accessed by psychiatrists. Site will hold treatment and assessment note on patients engaged in the IMPACT model which will be evaluated by supervising psychiatrist assigned to the patient.</td>
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<td>3 Develop a process for assigning patients to designated psychiatrist. Designations will be based primarily on patient's language, culture and relationship with the PCP and the community being served. This criteria will allow for a greater understanding of the patient's social conditions as well as a greater chance of compliance if psychiatrist face to face consult is required at a later time.</td>
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### Project Requirements

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<th>DY5,Q4</th>
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<tbody>
<tr>
<td><strong>Task</strong></td>
<td>Develop process by which Depression Care manager uploads patient information into Psychiatrist's secure site.</td>
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<td><strong>Milestone #13</strong></td>
<td>Measure outcomes as required in the IMPACT Model.</td>
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<td><strong>Task</strong></td>
<td>At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
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<td><strong>Task</strong></td>
<td>Incorporate assessment tools, ie. PHQ9 into PCP's EMR</td>
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<td><strong>Task</strong></td>
<td>Implement procedures for periodic repeat assessments in accordance with stepped care prescribed in evidence based protocol performed by the Depression care manager within the PCP's EMR.</td>
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<td><strong>Task</strong></td>
<td>Work with EMR vendors to Create filters and reportable fields that will allow the extrapolating of assessment data. ACP will rely on reportable data from MU dashboards, PCMH data fields, patient registries and others.</td>
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<td><strong>Task</strong></td>
<td>Use PCP's EMR to extrapolate comparison data, flow sheets to establish trends in symptoms based on assessment responses and measure outcomes.</td>
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<td><strong>Milestone #14</strong></td>
<td>Provide &quot;stepped care&quot; as required by the IMPACT Model.</td>
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<tr>
<td><strong>Task</strong></td>
<td>In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.</td>
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<td><strong>Task</strong></td>
<td>Implement Stepped care in accordance with ACP evidence based protocol, patients with positive PHQ9 values requiring treatment shall be treated as per specified treatment options and in stepped care by the PCP</td>
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<td><strong>Task</strong></td>
<td>Process is created for assignment of patient to Depression care manager for continuity of care and monitoring.</td>
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<td><strong>Task</strong></td>
<td>Process is created for continuous open lines of communication between Depression care manager and PCP, and on site care team as necessary.</td>
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**NYS Confidentiality – High**
## Project Requirements (Milestone/Task Name)

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<tr>
<td>4 In line with stepped care, Depression Care manager performs follow up PHQ9 assessment in intervals to ascertain effectiveness of treatment and make appropriate adjustments after consulting with PCP.</td>
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<td><strong>Milestone #15</strong> Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<td>Task 1 EHR demonstrates integration of medical and behavioral health record within individual patient records.</td>
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<td>Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td>Task 1 Working with EMR vendors, assessment tools are incorporated within EMRs in a format that is reportable in which data is ascertainable.</td>
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<td>Task 2 Develop process for extrapolating and reporting data to track and monitor all engaged patients.</td>
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<td>Task 3 Create FTP secure site and or other IDS platform for providing data to supervising psychiatrist and exchanging information.</td>
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<td>Task 4 Create connection and interfaces with other platforms including Care coordination/management platform, ACP IDS for open efficient exchange of information and more effective patient care.</td>
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## Prescribed Milestones Current File Uploads

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## Prescribed Milestones Narrative Text

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<th>Narrative Text</th>
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<tr>
<td>Co-locate behavioral health services at primary care practice sites. All participating primary care</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was</td>
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NYS Confidentiality – High
### Prescribed Milestones Narrative Text

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<td>practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.</td>
<td>permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
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<td>Develop collaborative evidence-based standards of care including medication management and care engagement process.</td>
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<tr>
<td>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.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
<td></td>
</tr>
<tr>
<td>Co-locate primary care services at behavioral health sites.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Develop collaborative evidence-based standards of care including medication management and care engagement process.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
<td></td>
</tr>
<tr>
<td>Implement IMPACT Model at Primary Care Sites.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.</td>
<td></td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
### Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employ a trained Depression Care Manager meeting requirements of the IMPACT model.</td>
<td></td>
</tr>
<tr>
<td>Designate a Psychiatrist meeting requirements of the IMPACT Model.</td>
<td></td>
</tr>
<tr>
<td>Measure outcomes as required in the IMPACT Model.</td>
<td></td>
</tr>
<tr>
<td>Provide &quot;stepped care&quot; as required by the IMPACT Model.</td>
<td></td>
</tr>
<tr>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
<td></td>
</tr>
</tbody>
</table>
### IPQR Module 3.a.i.5 - PPS Defined Milestones

**Instructions:**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

No Records Found

### PPS Defined Milestones Current File Uploads

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

No Records Found

### PPS Defined Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Records Found
IPQR Module 3.a.i.6 - IA Monitoring

Instructions:

Model 1, Milestone 1: The PPS should consider developing specific tasks to achieve milestone, the current plan does not provide enough detail and specificity as to how the PPS will reach the milestone.

Model 2, Milestone 7: Consider core physical health comorbidities like diabetes, hypertension, heart disease, COPD and other tobacco-related diseases as key physical health concerns for a behavioral health population.

Model 3, Milestone 9: Engagement needs to include the whole care team as physicians are only one part and IMPACT requires a whole workflow redesign: Ramp up my be overly ambitious, to get from zero to 46 sites by Q3 of DY1 and up to 902 by DyQ3. Must consider hiring and training of Depression Care Managers.
Project 3.b.i – Evidence-based strategies for disease management in high risk/affected populations (adult only)

☑ IPQR Module 3.b.i.1 - Major Risks to Implementation and Mitigation Strategies

Instructions:
Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Major risks to the implementation of this project revolve around ACP PPS serving a community that has low health literacy rates and who is of a culture that uses high sodium diets. Lifestyle modification in itself presents a high risk and a challenge since culture is important in these communities and maintaining a connection to those cultures is of utmost importance. Changing the culture of these patients and encouraging a culture foreseen as foreign is a great challenge. ACP PPS is suited and up to the task. It plans to mitigate this risk with its vast infrastructure of culturally aligned and linguistically competent providers who share the patient's concerns and can relate to the patient in a natural way through its community inbred primary care providers and community based organizations which are also culturally aligned with the patients. Our PCPs and CBOs will reach out to and follow up with the patients and promote health literacy and regimen compliance. Patients will receive care and education in a language and culture that they are comfortable with and will therefore be expected to be receptive to this intervention. Another risk to implementation is the socio-economic status of these patients which generally is a population below poverty level. These patients cannot afford exclusive diets and gymnasium membership. ACP plans to mitigate this risk by negotiating prime rates for its patients at fitness centers as well as educating the patient on physical exercise routines and diet that are affordable and effective.
IPQR Module 3.b.i.2 - Project Implementation Speed

Instructions:
Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application. Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>549</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>1,428</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinics</td>
<td>43</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>130</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>34</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>1,418</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>3,632</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent Committed Providers(%)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
IPQR Module 3.b.i.3 - Patient Engagement Speed

Instructions:

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application. Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Year, Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>111,709</td>
<td>135,647</td>
<td>159,585</td>
<td>72,611</td>
<td>207,461</td>
<td>263,316</td>
<td>319,171</td>
<td>72,611</td>
<td>143,626</td>
</tr>
<tr>
<td>% of Expected Patient Engagement</td>
<td>0.00</td>
<td>35.00</td>
<td>42.50</td>
<td>50.00</td>
<td>22.75</td>
<td>65.00</td>
<td>82.50</td>
<td>100.00</td>
<td>22.75</td>
<td>45.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year, Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>231,399</td>
<td>319,171</td>
<td>72,611</td>
<td>207,461</td>
<td>231,399</td>
<td>319,171</td>
<td>72,611</td>
<td>207,461</td>
<td>319,171</td>
<td>143,626</td>
</tr>
<tr>
<td>% of Expected Patient Engagement</td>
<td>72.50</td>
<td>100.00</td>
<td>22.75</td>
<td>65.00</td>
<td>72.50</td>
<td>100.00</td>
<td>22.75</td>
<td>65.00</td>
<td>72.50</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Current File Uploads

<table>
<thead>
<tr>
<th>User ID</th>
<th>File Name</th>
<th>File Description</th>
<th>Upload Date</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>No Records Found</td>
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</table>

Narrative Text:

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
**IPQR Module 3.b.i.4 - Prescribed Milestones**

Instructions:

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task: PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.</td>
<td>Project</td>
<td>Completed</td>
<td></td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td>Task 1: Working with physician leads and in accordance to American Heart Association and the JNC-8 recommendations and incorporating the guidelines of the US Preventive Services Task Force (USPSTF), develop evidence based protocol for the identification and management of cardiovascular disease and hyperlipidemia in the ambulatory practice.</td>
<td>Project</td>
<td>Completed</td>
<td></td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td>Task 2: Based on protocol guidelines for evaluation, create a reporting system using EMR registries to identify target patients, ie. Blood Pressure readings, Cholesterol levels.</td>
<td>Project</td>
<td>In Progress</td>
<td></td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 3: Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and educational services as needed.</td>
<td>Project</td>
<td>In Progress</td>
<td></td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 4: Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members. Protocols is also be made distributed electronically to every provider.</td>
<td>Project</td>
<td>In Progress</td>
<td></td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 5: Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.</td>
<td>Project</td>
<td>In Progress</td>
<td></td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task 6: User friendly materials are created on how to implement the protocol and how.</td>
<td>Project</td>
<td>Completed</td>
<td></td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
</tbody>
</table>
### Project Requirements

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>To enter searchable information into EMR for ease of reporting and performance and engagement monitoring.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task 7</strong> Implement Million hearts campaign</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task 8</strong> Care Teams are created regionally and information distributed to all PPS partners in order to better coordinate care and provide efficient services.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task 9</strong> Create Care Coordination/Care Management back office to assist in managing referrals, treatment plan adherence and coordinating social services as appropriate</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Milestone #2</strong> 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.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Non-PCP Practitioners</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Behavioral Health</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> PPS uses alerts and secure messaging functionality.</td>
<td>Provider</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task 1</strong> Partner with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task 2</strong> Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task 3</strong> Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task 4</strong> Develop other interim solutions for sharing health information among clinical partners using direct excepntient record lookup. Determine other needs or</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
</tbody>
</table>
## Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
Enhancements based on IT integration gap analyses. 04/01/2015-12/31/2015 |  |  |  |  |  |  |  
**Task**
5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available. | Project |  | In Progress | 07/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4
**Task**
6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available. | Project |  | In Progress | 07/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4
**Task**
7 Develop final plan for sharing health information among clinical partners by DY3. | Project |  | In Progress | 07/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4
**Task**
8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI. | Project |  | In Progress | 10/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4
**Milestone #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. | Project | N/A | In Progress | 07/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4
**Task**
EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria). | Project |  | In Progress | 07/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4
**Task**
PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM. | Provider | Primary Care Physicians | In Progress | 07/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4
**Task**
1 Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai. | Project |  | In Progress | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
**Task**
2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (i.e. those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records). | Project |  | In Progress | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
**Task**
3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources. | Project |  | In Progress | 07/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
**Task**
4 Start to implement plan to ensure safety net providers achieve MU/PCMH | Project |  | In Progress | 01/01/2016 | 03/31/2018 | 03/31/2018 | DY3 Q4
## Project Requirements
(Milestone/Task Name)  

<table>
<thead>
<tr>
<th>Reporting Level</th>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.</td>
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</table>

### Milestone #4

Use EHRs or other technical platforms to track all patients engaged in this project.

**Task**

PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

**Task**

1. Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.

**Task**

2. Create "how to" training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.

**Task**

3. Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as BP levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.

### Milestone #5

Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).

**Task**

PPS has implemented an automated scheduling system to facilitate tobacco control protocols.

**Task**

PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.

**Task**

1. Organize tobacco assessment tools within the EMR and create mandatory
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Advocate Community Providers, Inc.  (PPS ID:25)

<table>
<thead>
<tr>
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<th>Quarter End Date</th>
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</thead>
<tbody>
<tr>
<td>Fields where the provider is prompted and obligated to record tobacco use assessment and counseling for users. Leverage meaningful use requirements and systems to assist in these prompts.</td>
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<tr>
<td><strong>Task</strong> 2 Create evidence based protocols for tobacco use cessation incorporating the 5 A’s.</td>
<td>Project</td>
<td>Completed</td>
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<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 3 Distribute protocols and train practices on documentation and process within the protocols and how to use the assessment tools. Protocol shall be distributed in physician engagement meetings, by provider engagement teams, and in electronic forms. Provider engagement teams will provide training on processes and implementation to these at onsite visits and trainings. The provider engagement team visits will be ongoing and used to provide periodic trainings and updates on protocols, processes and updates.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td><strong>Milestone #6</strong> Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
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<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task</strong> Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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<tr>
<td><strong>Task</strong> 1 Develop/create evidence based protocols for Cardio vascular disease to include evaluation and treatment of hyperlipidemia as approved by ACP physician leads in accordance with JNC-8, American Heart Association, and USPSTF.</td>
<td>Project</td>
<td>Completed</td>
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<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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<tr>
<td><strong>Task</strong> 2 Leverage existing physician groups to reach and obtain “buy in” of physician partners in ACP protocols and processes.</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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</tr>
<tr>
<td><strong>Task</strong> 3 Use provider engagement teams, physician engagement meetings, Care Teams to establish rapport with providers and distribute and train in the adoption of the evidence based protocols and standards of care.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td><strong>Task</strong> 4 ACP has provider participation agreements in place with its providers in which there is an acceptance as to following ACP processes including standards of care and metric reporting.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
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<tr>
<td><strong>Milestone #7</strong> Develop care coordination teams including use of nursing staff, pharmacists,</td>
<td>Project</td>
<td>N/A</td>
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</thead>
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<tr>
<td>dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td><strong>Task</strong> Clinically Interoperable System is in place for all participating providers.</td>
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<td>In Progress</td>
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<td>DY2 Q1</td>
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<tr>
<td>Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
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<td><strong>Task</strong> Care coordination processes are in place.</td>
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<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>1 Establish ACP PMO back office central hub which includes team of care coordinators, care managers, community health workers, outreach staff.</td>
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<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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<tr>
<td>2 Create training materials for patient education and self-management in different languages taking into consideration the language and culture of the target population.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>3 Create Care Coordination processes and procedures</td>
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<td>06/30/2016</td>
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<tr>
<td>4 Train back office staff in ACP care coordination processes in accordance with project requirements and project specific protocol implementation.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>5 Train back office staff, care managers, care coordinators in patient self-management techniques as per the ACP created and disseminated patient self-management training materials. Staff will learn what the coordination requirements are as per the established protocols and ACP processes. They will learn implementation of protocol specific techniques in language and culturally appropriate manner.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
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<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td>6 Establish Care Teams ensuring inclusion of pharmacists, nutritional counselors, and other ancillary providers including DME vendors, diagnostic entities, etc. that back office will coordinate.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>7 Train back office staff care managers and care coordinators in lifestyle coaching and providing educational materials in language appropriate and culturally sensitive manner.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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<tr>
<td>8 Establish Care Teams ensuring inclusion of pharmacists, nutritional counselors, and other ancillary providers including DME vendors, diagnostic entities, etc. that back office will coordinate.</td>
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<tr>
<td></td>
<td>Train and utilize Community health workers to approach and educate target populations to increase health literacy, self awareness and disease management and prevention.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<td></td>
<td>Utilize community health workers to liaise with CBOs to hold Stanford Model educational seminars within the communities in a culturally sensitive and language appropriate forum.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<td></td>
<td>Implement IDS consistent with project 2.a.i to have a integration of information centralized and accessible for more efficient and effective care. The IDS will utilize interfaces and connections for two way interchange of information between physician EMRs, hospital EMRs, CBOs and other entities all of which the central Care coordination teams will be able to access for follow up and follow through.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td></td>
<td>Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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</table>

### Milestone #8

Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.

<table>
<thead>
<tr>
<th>Task</th>
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<tr>
<td></td>
<td>All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
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<tr>
<td></td>
<td>PPS negotiates with MCOs to assure that no copays are deemed necessary for BP checks.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td></td>
<td>Process and procedure manual and agreement with PCPs to also stipulate need to fit patient into schedule to be seen by provider if BP values are at unacceptable levels.</td>
<td>Project</td>
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<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
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### Milestone #9

Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.

<table>
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<tr>
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</tr>
<tr>
<td></td>
<td>PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.</td>
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<td>06/30/2016</td>
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</tr>
<tr>
<td></td>
<td>Develop training manuals for training of office staff at all levels on proper</td>
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<td>06/30/2016</td>
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</table>
### Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Technique and equipment use for accurate BP measurement. Training manual also to include acceptable and non-acceptable values, to prompt staff to seek physician intervention upon attainment of unacceptable values.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task</strong></td>
</tr>
<tr>
<td>2 Implement training to all staff regarding BP measurement. Provider engagement teams provide on-site training to practice staff on BP measurement manual and obtain staff training certifications to be provided to Workforce office for monitoring and reporting.</td>
</tr>
<tr>
<td>Reporting Level</td>
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<tr>
<td>Project</td>
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</tbody>
</table>

#### Milestone #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.

<table>
<thead>
<tr>
<th>PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task</strong></td>
</tr>
<tr>
<td>PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
</tr>
<tr>
<td>PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.</td>
</tr>
<tr>
<td><strong>Task</strong></td>
</tr>
<tr>
<td>1 Develop data pull frequencies to utilize EMR patient registries to identify blood-pressure values.</td>
</tr>
<tr>
<td>2 Create analytics tool to cross analyze BP values against those with Cardiovascular diagnosis, ie diagnosis of Hypertension and number of encounters with elevated blood-pressure values.</td>
</tr>
<tr>
<td>3 Create process for reporting to Central hub and to PCP findings of analytics report.</td>
</tr>
<tr>
<td>4 Create process for receiving patient data for those identified via the data analysis and providing outreach to these patients to schedule for PCP visit and early intervention. Outreach may be provided at the central level via community health workers if needed or at the local level by the PCP office when patient is reachable and known to them.</td>
</tr>
<tr>
<td><strong>Task</strong></td>
</tr>
<tr>
<td>5 Processes for identification and periodicity of visits to be updated periodically.</td>
</tr>
<tr>
<td>Reporting Level</td>
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<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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</tbody>
</table>

### Task 1
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.

### Task 2
Train physicians on implementation of evidence-based protocols and provide assistance and follow up.

### Task 3
Clinical Quality Committee Review CV evidence based protocols periodically and minimally yearly to revise and update as per latest advances and recommendations.

### Milestone #12
Document patient-driven self-management goals in the medical record and review with patients at each visit.

### Task 1
Self-management goals are documented in the clinical record.

### Task 2
PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.

### Task 3
1. As per evidence-based protocols, train providers on setting self-management goals for the individual patient. Self-management goals may be updated as per updated protocols upon review by the Clinical Quality Committee.

### Task 4
2. Provide training to staff on monitoring the patient's progress on self-management goal as per set goals according to protocols. Re-Training will be periodic and minimally yearly, though may be sooner if protocol needs updating.
### DSRIP Implementation Plan Project

**Advocate Community Providers, Inc. (PPS ID:25)**

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
<td>3 Work with EMR vendors to Create and Provide structured data fields within the EMRs where self-management goals can be easily identified and progress on such can be reportable.</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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</tr>
<tr>
<td><strong>Task</strong> 4 Train providers and staff on entering self-management goals data entering and monitoring.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Milestone #13</strong> Follow up with referrals to community based programs to document participation and behavioral and health status changes.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> PPS has developed referral and follow-up process and adheres to process.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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</tr>
<tr>
<td><strong>Task</strong> PPS provides periodic training to staff on warm referral and follow-up process.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> 1 Engage PCPs and train on and implement cardiovascular (CV) evidence based protocols ensuring attention to identification of behavioral health status and referral criteria.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> 2 Create protocol and processes for realization of &quot;warm handoffs&quot; when patients identified as needing behavioral health services. Utilize physician engagement team to implement and train staff at PCP office on &quot;warm handoffs&quot; of patients needing behavioral health services.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> 3 Provide PCPs with care teams' information and referral processes for providing referrals to and receiving information from CBOs, Behavioral and Mental health partners.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> 4 Establish central back office inclusive of care coordinators, care managers, community health workers and outreach staff with interfaces and two way connections that allow for upload of referrals as they are created by partners and as they are processed.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong> 5 Establish and implement processes by which care coordinators receive and follow referrals as they are uploaded into Care management system electronically.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task</strong></td>
<td>Project</td>
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<td>10/01/2015</td>
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NYS Confidentiality – High
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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
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<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 Establish and implement process and procedures by which care coordinators intervene in assisting patients in coordinating needed services from the full range of ACP partner providers and community based organizations, local government and specialty agencies.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 7 Establish process by which care coordinator central or at the practice site ensures receipt of services by patient and marks to send back to referring provider the result and outcome of services received by patient using.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 8 Develop and implement procedures for warm handoffs as in previous tasks.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 9 Establish periodicity of staff retraining to ensure comprehension and adherence to processes. Retraining to be minimally yearly but optimally twice yearly.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 10 Perform analysis of CNA to determine community resources available.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 11 Perform network analysis to determine size and scope of necessary resources</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 12 Draft CBO agreements and present to Board for approval. The CBO agreements will include services to be provided, timeliness of provision of services, ability and commitment to timely information exchange.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 13 Utilize Community Engagement teams to Distribute RFP to CBOs to evaluate services, timeliness of services and CBO's capacity.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 14 Utilize Community Engagement team to establish rapport, present formal agreements and obtain signed formal agreements.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td>Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task PPS has developed and implemented protocols for home blood pressure monitoring.</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
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</table>
### Project Requirements

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task PPS provides periodic training to staff on warm referral and follow-up process.</td>
<td>Project</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 1 Develop training manual for patients on how to measure BP. The manual includes proper technique and equipment use. The manual also contains guidance on values and goals with instruction on alert values and how to document the values.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 2 Distribute BP manual to all practices for implementation and release to patients.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 3 Engage physicians and their staff in implementation of manual and training the patient. The physician engagement team shall provide in-house training to physicians and all practice staff on how to use the training manual and how to train the patient on proper BP measuring.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 4 Processes are put in place at PCP offices for staff to accept and evaluate patient's BP logs which the patient shall bring to every visit.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 5 Staff is trained as per BP manual on evaluating equipment. BP levels measured at PCP office with patient equipment may be compared to readings at PCP office using office equipment.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
<td>Project</td>
<td>N/A</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 1 Establish process for monthly data pulls from EMR registries for all patients with Hypertensive Cardiovascular disease by ICD code</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 2 Create filters for cross reference of reports pulled from EMR registries with parameters for all patients with hypertensive CV disease by ICD code/due to the next visit. Identify all patients without a follow up appointment or who skipped a scheduled encounter.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 3 Establish process for outreach to target patients and schedule a prompt appointment. PCPs allow for timely scheduling of the appointments.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
</tbody>
</table>
## Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
Task 1 Establish process for staff to communicate to CHWs patient lists/rosters who miss more than one appointment or are not reachable. CHW will provide services within the community and work to find the patient and connect the patient back to the PCP. | Project | | In Progress | 01/01/2016 | 06/30/2016 | 06/30/2016 | DY2 Q1

### Milestone #16
Facilitate referrals to NYS Smoker's Quitline. | Project | N/A | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3

### Task
PPS has developed referral and follow-up process and adheres to process. | Project | | In Progress | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2

### Task
1 Establish procedures in accordance with evidence based protocols for referrals of tobacco users to NYS Smoker's Quitline. | Project | | In Progress | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2

### Task
2 Implement process for care coordinators and CHWs to receive and access referrals and follow up to ensure compliance and assist in care plan. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3

### Milestone #17
Perform additional actions including “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases. | Project | N/A | In Progress | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3

### Task
If applicable, PPS has implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities. | Project | | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4

### Task
If applicable, PPS has established linkages to health homes for targeted patient populations. | Project | | In Progress | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1

### Task
If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations. | Project | | In Progress | 01/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3

### Task
1 Perform CNA analysis to determine “hot spots”. Determine neighborhoods with highest risk. | Project | | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3

### Task
2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities. | Project | | In Progress | 01/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3

### Task
3 Utilize EMR technology to gather pertinent information. Activate features | Project | | In Progress | 10/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1

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Advocate Community Providers, Inc.  (PPS ID:25)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.</td>
<td></td>
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</tr>
<tr>
<td>Task 4 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 5 As in previous tasks, Utilize community health workers to identify and establish agreements with CBOs that will then serve for implementation of Stanford model.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
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<tr>
<td>Milestone #18 Adopt strategies from the Million Hearts Campaign.</td>
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<td>In Progress</td>
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<td>12/31/2016</td>
<td>12/31/2016</td>
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<tr>
<td>Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td>Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
<td>Provider</td>
<td>Non-PCP Practitioners</td>
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<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
<td>Provider</td>
<td>Behavioral Health</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task 1 With physician leads, Create ACP Million Hearts Campaign implementation and training materials.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 2 Distribute Million Hearts Campaign implementation materials to all PCPs at physician engagement meetings, in person by Physician engagement team member, electronically.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 3 Physician engagement team to provide PCPs training on million hearts campaign implementation to include BP checks without appointments, without copays, staff training and re-training and identifying a designated BP check area.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 4 Working with community enterprises, organizations, MCOs and Physicians; ACP’s Community Engagement team will negotiate and create patient compliance incentives to assist in motivating patients to adhere to treatment plans</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
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<td>Task</td>
<td>Project</td>
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### Project Requirements (Milestone/Task Name)

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<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
<td>5 Develop processes in accordance with million hearts campaign including patient self-management educational materials to be distributed to target patients and training provided at point of care in provider office.</td>
<td></td>
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</tr>
<tr>
<td><strong>Task</strong> 6 Develop patient training and educational materials for patient disease self-management techniques including how to monitor and record blood pressure levels at home.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
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<tr>
<td><strong>Task</strong> 7 Develop Lifestyle modification teaching and training materials including nutritional counseling.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>8 In accordance with Million Hearts Campaign, Develop staff retraining tools and manuals and use provider engagement team to provide individual practice's staff members retraining on how to monitor blood pressures to ensure that patients can walk in to the practice and have their BP checked by any staff member at any time. The process will ensure that each staff member knows the correct technique and value assessment at the time that the patient comes in and is trained on the process to bring out of range values to the immediate attention of the provider.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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</tr>
<tr>
<td><strong>Milestone #19</strong> Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 1 Leverage existing relationships with MCOs to negotiate extended coverage for target and affected population. The negotiating to include coverage for items such as BP machines for every patient with Hypertension, Nutritional counseling, smoking cessation medications and counseling as well as others.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 2 Utilize existing relationships to negotiate and form agreements with MCOs by which copays are waived for BP check exams.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #20</strong> Engage a majority (at least 80%) of primary care providers in this project.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Task</strong> PPS has engaged at least 80% of their PCPs in this activity.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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</table>
### Project Requirements

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Leverage relationships within physician groups, IPAs, etc to engage physicians in ACP values.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>2 Working with the finance department, formulate incentives for PCP participation.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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</tr>
<tr>
<td>3 Through physician engagement meetings, physician engagement teams, physician champions and other relationships; foster tight relationships with physicians and obtain agreements of participation with at least 80% of PCPs in ACP’s network.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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### Project Requirements (Milestone/Task Name)

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<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
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<th>DY1,Q4</th>
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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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</thead>
<tbody>
<tr>
<td>Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.</td>
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<tr>
<td>PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.</td>
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<tr>
<td>1 Working with physician leads and in accordance to American Heart Association and the JNC-8 recommendations and incorporating the guidelines of the US Preventive Services Task Force (USPSTF), develop evidence based protocol for the identification and management of cardiovascular disease and hyperlipidemia in the ambulatory practice.</td>
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<tr>
<td>2 Based on protocol guidelines for evaluation, create a reporting system using EMR registries to identify target patients, ie. Blood Pressure readings, Cholesterol levels.</td>
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<tr>
<td>3 Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and educational services as needed.</td>
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<td>4 Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members.</td>
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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name)

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<thead>
<tr>
<th>Task</th>
<th>Project Requirements</th>
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<tbody>
<tr>
<td>5</td>
<td>Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.</td>
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<tr>
<td>6</td>
<td>User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.</td>
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<tr>
<td>7</td>
<td>Implement Million hearts campaign</td>
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<td>8</td>
<td>Care Teams are created regionally and information distributed to all PPS partners in order to better coordinate care and provide efficient services.</td>
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<tr>
<td>9</td>
<td>Create Care Coordination/Care Management back office to assist in managing referrals, treatment plan adherence and coordinating social services as appropriate</td>
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</tbody>
</table>

### Milestone #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.

<table>
<thead>
<tr>
<th>Task</th>
<th>Project Requirements</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td></td>
<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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</tbody>
</table>

### Task 1

Partner with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.
## Project Requirements

<table>
<thead>
<tr>
<th>(Milestone/Task Name)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
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<td>Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.</td>
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<tr>
<td>Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.</td>
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<tr>
<td>Develop other interim solutions for sharing health information among clinical partners using direct epatient record lookup. Determine other needs or enhancements based on IT/integration gap analyses. 04/01/2015-12/31/2015</td>
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<td>Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.</td>
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<td>Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.</td>
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<td>Develop final plan for sharing health information among clinical partners by DY3.</td>
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<td>Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.</td>
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<tr>
<td>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.</td>
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<td><strong>Task 8</strong></td>
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<tr>
<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
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</table>

### Milestone #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.
- EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).

### Task

- PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.
  - 0 0 0 0 0 0 0 0 55 110 193

### Task 1

- Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.

### Task 2

- Develop plan, timelines, and assign resources for each level
of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).

**Task 3** Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.

**Task 4** Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.

**Milestone #4**

Use EHRs or other technical platforms to track all patients engaged in this project.

**Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting;**

**Task 1** Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.

**Task 2** Create "how to" training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.

**Task 3** Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as BP levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.

**Milestone #5**

Use the EHR to prompt providers to complete the 5 A’s of
## Project Requirements

<table>
<thead>
<tr>
<th>(Milestone/Task Name)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
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<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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</thead>
<tbody>
<tr>
<td><strong>tobacco control</strong> (Ask, Assess, Advise, Assist, and Arrange).</td>
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<tr>
<td>PPS has implemented an automated scheduling system to facilitate tobacco control protocols.</td>
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<td>PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.</td>
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<tr>
<td>Task 1 Organize tobacco assessment tools within the EMR and create mandatory fields where the provider is prompted and obligated to record tobacco use assessment and counseling for users. Leverage meaningful use requirements and systems to assist in these prompts.</td>
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<tr>
<td>2 Create evidence based protocols for tobacco use cessation incorporating the 5 A's.</td>
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<td>3 Distribute protocols and train practices on documentation and process within the protocols and how to use the assessment tools. Protocol shall be distributed in physician engagement meetings, by provider engagement team, and in electronic forms. Provider engagement teams will provide training on processes and implementation to these at onsite visits and trainings. The provider engagement team visits will be ongoing and used to provide periodic trainings and updates on protocols, processes and updates.</td>
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<td>Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.</td>
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<td>Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).</td>
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<tr>
<td>1 Develop/create evidence based protocols for Cardio vascular disease to include evaluation and treatment of hyperlipidemia as approved by ACP physician leads in accordance with JNC-8, American Heart Association, and USPSTF.</td>
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<td>2 Leverage existing physician groups to reach and obtain &quot;buy in&quot; of physician partners in ACP protocols and processes.</td>
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<tr>
<td>3 Use provider engagement teams, physician engagement</td>
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## Project Requirements (Milestone/Task Name)

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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tbody>
<tr>
<td>1 Establish ACP PMO back office central hub which includes team of care coordinators, care managers, community health workers, outreach staff.</td>
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<td>2 Create training materials for patient education and self-management in different languages taking into consideration the language and culture of the target population.</td>
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<tr>
<td>3 Create Care Coordination processes and procedures</td>
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<td>4 Train back office staff in ACP care coordination processes in accordance with project requirements and project specific protocol implementation.</td>
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<td>5 Train back office staff, care managers, care coordinators in patient self-management techniques as per the ACP created and disseminated patient self-management training materials. Staff will learn what the coordination requirements are as per the established protocols and ACP processes. They will learn implementation of protocol specific techniques in language and culturally appropriate manner.</td>
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<td>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.</td>
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<td>Clinically Interoperable System is in place for all participating providers.</td>
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<tr>
<td>Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
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<td>Care coordination processes are in place.</td>
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<td>Meetings, Care Teams to establish rapport with providers and distribute and train in the adoption of the evidence based protocols and standards of care.</td>
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<td>4 ACP has provider participation agreements in place with its providers in which there is an acceptance as to following ACP processes including standards of care and metric reporting.</td>
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### Project Requirements

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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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</thead>
<tbody>
<tr>
<td><strong>Task</strong> 6 Establish Care Teams ensuring inclusion of pharmacists, nutritional counselors, and other ancillary providers including DME vendors, diagnostic entities, etc. that back office will coordinate</td>
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<tr>
<td><strong>Task</strong> 7 Train back office staff care managers and care coordinators in lifestyle coaching and providing educational materials in language appropriate and culturally sensitive manner</td>
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<tr>
<td><strong>Task</strong> 8 Train and utilize Community health workers to approach and educate target populations to increase health literacy, self awareness and disease management and prevention.</td>
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<tr>
<td><strong>Task</strong> 9 Utilize community health workers to liaise with CBOs to hold Stanford Model educational seminars within the communities in a culturally sensitive and language appropriate forum.</td>
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<tr>
<td><strong>Task</strong> 10 Implement IDS consistent with project 2.a.i to have a integration of information centralized and accessible for more efficient and effective care. The IDS will utilize interfaces and connections for two way interchange of information between physician EMRs, hospital EMRs, CBOs and other entities all of which the central Care coordination teams will be able to access for follow up and follow through.</td>
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<td><strong>Milestone #8</strong> Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
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<tr>
<td><strong>Task</strong> All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.</td>
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<tr>
<td><strong>Task</strong> 1 As required in ACP’s protocol and processes, agreements are made with all PCPs that provide for the opportunity for patients to have BP monitored as walk ins, without appointments and without copay.</td>
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<td><strong>Task</strong> 2 PPS negotiates with MCOs to assure that no copays are deemed necessary for BP checks.</td>
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<td><strong>Task</strong> 3 Process and procedure manual and agreement with PCPs to also stipulate need to fit patient into schedule to be seen by provider if BP values are at unacceptable levels.</td>
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<tr>
<td><strong>Milestone #9</strong> Ensure that all staff involved in measuring and recording blood</td>
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NYS Confidentiality – High
# Project Requirements

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<th>DY2,Q4</th>
<th>DY3,Q1</th>
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<tbody>
<tr>
<td>pressure are using correct measurement techniques and equipment.</td>
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<td><strong>Task</strong></td>
<td>PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.</td>
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<tr>
<td>Task 1 Develop training manuals for training of office staff at all levels on proper technique and equipment use for accurate BP measurement. Training manual also to include acceptable and non-acceptable values, to prompt staff to seek physician intervention upon attainment of unacceptable values.</td>
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<tr>
<td>Task 2 Implement training to all staff regarding BP measurement. Provider engagement teams provide on-site training to practice staff on BP measurement manual and obtain staff training certifications to be provided to Workforce office for monitoring and reporting.</td>
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<td><strong>Milestone #10</strong></td>
<td>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.</td>
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<tr>
<td>Task</td>
<td>PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.</td>
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<td>Task</td>
<td>PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<td>Task</td>
<td>PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.</td>
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<td>Task</td>
<td>1 Develop data pull frequencies to utilize EMR patient registries to identify blood-pressure values.</td>
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<td>Task</td>
<td>2 Create analytics tool to cross analyze BP values against those with Cardiovascular diagnosis, ie diagnosis of Hypertension and number of encounters with elevated blood-pressure values.</td>
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<td>Task</td>
<td>3 Create process for reporting to Central hub and to PCP findings of analytics report.</td>
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<td>Task</td>
<td>4 Create process for receiving patient data for those identified via the data analysis and providing outreach to these patients to</td>
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schedule for PCP visit and early intervention. Outreach may be provided at the central level via community health workers if needed or at the local level by the PCP office when patient is reachable and known to them.

<table>
<thead>
<tr>
<th>Task</th>
<th>Milestone #11</th>
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<tbody>
<tr>
<td>5 Processes for identification and periodicity of visits to be updated periodically, and minimally yearly by Clinical Quality Committee and staff retraining to be repeated as necessary, minimally yearly to keep up to date on process updates.</td>
<td>Prescribe once-daily regimens or fixed-dose combination pills when appropriate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone #11</th>
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<tbody>
<tr>
<td>PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.</td>
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<thead>
<tr>
<th>Task</th>
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<tbody>
<tr>
<td>1 Implement ACP evidence based CV protocol created in accordance with JNC recommendations, which calls for once daily regimens and includes preferential drugs as appropriate in a format that is user friendly and understandable.</td>
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<tr>
<th>Task</th>
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<tbody>
<tr>
<td>2 Clinical Quality Committee Review CV evidence based protocols periodically and minimally yearly to revise and update as per latest advances and recommendations.</td>
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<thead>
<tr>
<th>Milestone #12</th>
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<tr>
<td>Self-management goals are documented in the clinical record.</td>
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<th>Task</th>
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<tbody>
<tr>
<td>PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.</td>
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<th>Task</th>
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<tr>
<td>Provide training to staff on monitoring the patient's progress on self-management goal as per set goals according to protocols. Re-Training will be periodic and minimally yearly.</td>
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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name)

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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tr>
<td>3 Work with EMR vendors to Create and Provide structured data fields within the EMRs where self-management goals can be easily identified and progress on such can be reportable.</td>
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<tr>
<td>4 Train providers and staff on entering self-management goals data entering and monitoring.</td>
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<td>Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.</td>
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<td>PPS has developed referral and follow-up process and adheres to process.</td>
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<tr>
<td>PPS provides periodic training to staff on warm referral and follow-up process.</td>
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<td>Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.</td>
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<tr>
<td>1 Engage PCPs and train on and implement cardiovascular (CV) evidence based protocols ensuring attention to identification of behavioral health status and referral criteria.</td>
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<tr>
<td>2 Create protocol and processes for realization of &quot;warm handoffs&quot; when patients identified as needing behavioral health services. Utilize physician engagement team to implement and train staff at PCP office on &quot;warm handoffs&quot; of patients needing behavioral health services.</td>
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<td>3 Provide PCPs with care teams' information and referral processes for providing referrals to and receiving information from CBOs, Behavioral and Mental health partners.</td>
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<tr>
<td>4 Establish central back office inclusive of care coordinators, care managers, community health workers and outreach staff with interfaces and two way connections that allow for upload of referrals as they are created by partners and as they are processed.</td>
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<td>5 Establish and implement processes by which care</td>
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<tr>
<td>coordinators receive and follow referrals as they are uploaded into Care management system electronically.</td>
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<tr>
<td><strong>Task</strong> 6 Establish and implement process and procedures by which care coordinators intervene in assisting patients in coordinating needed services from the full range of ACP partner providers and community based organizations, local government and specialty agencies.</td>
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<td><strong>Task</strong> 7 Establish process by which care coordinator central or at the practice site ensures receipt of services by patient and marks to send back to referring provider the result and outcome of services received by patient using.</td>
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<td><strong>Task</strong> 8 Develop and implement procedures for warm handoffs as in previous tasks.</td>
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<td><strong>Task</strong> 9 Establish periodicity of staff retraining to ensure comprehension and adherence to processes. Retraining to be minimally yearly but optimally twice yearly.</td>
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<td><strong>Task</strong> 10 Perform analysis of CNA to determine community resources available.</td>
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<td><strong>Task</strong> 11 Perform network analysis to determine size and scope of necessary resources</td>
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<td><strong>Task</strong> 12 Draft CBO agreements and present to Board for approval. The CBO agreements will include services to be provided, timeliness of provision of services, ability and commitment to timely information exchange.</td>
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<td><strong>Task</strong> 13 Utilize Community Engagement teams to Distribute RFP to CBOs to evaluate services, timeliness of services and CBO's capacity.</td>
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<td><strong>Task</strong> 14 Utilize Community Engagement team to establish rapport, present formal agreements and obtain signed formal agreements.</td>
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<tr>
<td><strong>Milestone #14</strong> Develop and implement protocols for home blood pressure monitoring with follow up support.</td>
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<tr>
<td><strong>Task</strong> PPS has developed and implemented protocols for home blood pressure monitoring.</td>
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<td>PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.</td>
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<td>PPS provides periodic training to staff on warm referral and follow-up process.</td>
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<tr>
<td>1 Develop training manual for patients on how to measure BP. The manual includes proper technique and equipment use. The manual also contains guidance on values and goals with instruction on alert values and how to document the values.</td>
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<td>2 Distribute BP manual to all practices for implementation and release to patients.</td>
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<td>3 Engage physicians and their staff in implementation of manual and training the patient. The physician engagement team shall provide in-house training to physicians and all practice staff on how to use the training manual and how to train the patient on proper BP measuring.</td>
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<td>4 Processes are put in place at PCP offices for staff to accept and evaluate patient's BP logs which the patient shall bring to every visit.</td>
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<td>5 Staff is trained as per BP manual on evaluating equipment. BP levels measured at PCP office with patient equipment may be compared to readings at PCP office using office equipment.</td>
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<td>Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<td>PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<tr>
<td>1 Establish process for monthly data pulls from EMR registries for all patients with Hypertensive Cardiovascular disease by ICD code</td>
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<tr>
<td>2 Create filters for cross reference of reports pulled from EMR registries with parameters for all patients with hypertensive CV disease by ICD code/ date of last encounter/ and date of next visit. Identify all patients without a follow up appointment or who skipped a scheduled encounter.</td>
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NYS Confidentiality – High
### Project Requirements

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<th>(Milestone/Task Name)</th>
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<td>3 Establish process for outreach to target patients and schedule a prompt appointment. PCPs allow for timely scheduling of the appointments.</td>
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<td>4 Establish process for staff to communicate to CHWs patient lists/rosters who miss more than one appointment or are not reachable. CHW will provide services within the community and work to find the patient and connect the patient back to the PCP.</td>
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<td>Facilitate referrals to NYS Smoker's Quitline.</td>
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<td>PPS has developed referral and follow-up process and adheres to process.</td>
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<tr>
<td>1 Establish procedures in accordance with evidence based protocols for referrals of tobacco users to NYS Smoker's Quitline.</td>
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<td>Implement process for care coordinators and CHWs to receive and access referrals and follow up to ensure compliance and assist in care plan.</td>
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<td>Perform additional actions including “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.</td>
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<td>If applicable, PPS has implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.</td>
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<td>If applicable, PPS has established linkages to health homes for targeted patient populations.</td>
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<td>If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.</td>
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<tr>
<td>1 Perform CNA analysis to determine “hot spots”. Determine neighborhoods with highest risk.</td>
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<tr>
<td>2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot</td>
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## Project Requirements

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<td><strong>Utilize EMR technology to gather pertinent information.</strong></td>
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<td><strong>Activate features within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.</strong></td>
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<td><strong>Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.</strong></td>
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<td><strong>As in previous tasks, Utilize community health workers to identify and establish agreements with CBOs that will then serve for implementation of Stanford model.</strong></td>
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<td><strong>Adopt strategies from the Million Hearts Campaign.</strong></td>
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**Task**

- Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.

**Task**

- Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.

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<td><strong>With physician leads, Create ACP Million Hearts Campaign implementation and training materials.</strong></td>
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<td><strong>Distribute Million Hearts Campaign implementation materials to all PCPs at physician engagement meetings, in person by Physician engagement team member, electronically.</strong></td>
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<td><strong>Physician engagement team to provide PCPs training on million hearts campaign implementation to include BP checks without appointments, without copays, staff training and re-training and identifying a designated BP check area.</strong></td>
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<td><strong>Working with community enterprises, organizations, MCOs and Physicians; ACP’s Community Engagement team will</strong></td>
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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name)

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<tr>
<th>Task</th>
<th>Description</th>
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<tbody>
<tr>
<td>5</td>
<td>Develop processes in accordance with million hearts campaign including patient self-management educational materials to be distributed to target patients and training provided at point of care in provider office.</td>
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<tr>
<td>6</td>
<td>Develop patient training and educational materials for patient disease self-management techniques including how to monitor and record blood pressure levels at home.</td>
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<td>7</td>
<td>Develop Lifestyle modification teaching and training materials including nutritional counseling.</td>
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<td>8</td>
<td>In accordance with Million Hearts Campaign, Develop staff retraining tools and manuals and use provider engagement team to provide individual practice's staff members retraining on how to monitor blood pressures to ensure that patients can walk in to the practice and have their BP checked by any staff member at any time. The process will ensure that each staff member knows the correct technique and value assessment at the time that the patient comes in and is trained on the process to bring out of range values to the immediate attention of the provider.</td>
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<tr>
<td><strong>Milestone #19</strong></td>
<td>Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.</td>
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<tr>
<td><strong>Task</strong></td>
<td>PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
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<tr>
<td><strong>Task</strong></td>
<td>Leverage existing relationships with MCOs to negotiate extended coverage for target and affected population. The negotiating to include coverage for items such as BP machines for every patient with Hypertension, Nutritional counseling, smoking cessation medications and counseling as well as others.</td>
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<tr>
<td><strong>Task</strong></td>
<td>Utilize existing relationships to negotiate and form agreements with MCOs by which copays are waived for BP</td>
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**NYS Confidentiality – High**
## Project Requirements

### Milestone #20

Engage a majority (at least 80%) of primary care providers in this project.

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<tbody>
<tr>
<td>PPS has engaged at least 80% of their PCPs in this activity.</td>
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### Task

1. Leverage relationships within physician groups, IPAs, etc to engage physicians in ACP values.
2. Working with the finance department, formulate incentives for PCP participation.
3. Through physician engagement meetings, physician engagement teams, physician champions and other relationships; foster tight relationships with physicians and obtain agreements of participation with at least 80% of PCPs in ACP's network.

### Milestone #1

Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.

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<th>Task</th>
<th>DY3,Q3</th>
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<tr>
<td>PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.</td>
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<tr>
<td>1 Working with physician leads and in accordance to American Heart Association and the JNC-8 recommendations and incorporating the guidelines of the US Preventive Services Task Force (USPSTF), develop evidence based protocol for the identification and management of cardiovascular disease and hyperlipidemia in the ambulatory practice.</td>
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<td>2 Based on protocol guidelines for evaluation, create a reporting system using EMR registries to identify target patients, ie. Blood Pressure readings, Cholesterol levels.</td>
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<td>3 Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and</td>
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## Project Requirements (Milestone/Task Name)

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<td>educational services as needed.</td>
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**Task**

4 Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members. Protocols is also be made distributed electronically to every provider.

**Task**

5 Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.

**Task**

6 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.

**Task**

7 Implement Million hearts campaign

**Task**

8 Care Teams are created regionally and information distributed to all PPS partners in order to better coordinate care and provide efficient services.

**Task**

9 Create Care Coordination/Care Management back office to assist in managing referrals, treatment plan adherence and coordinating social services as appropriate

### Milestone #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.

**Task**

|----------------|-------|--------|--------|--------|--------|--------|--------|--------|--------|--------|

**Task**

EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 348 | 496 | 496 | 496 | 496 | 496 | 496 | 496 | 496 | 496 |
|----------------|-------|--------|--------|--------|--------|--------|--------|--------|--------|--------|

**Task**

EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. | 68 | 96 | 96 | 96 | 96 | 96 | 96 | 96 | 96 | 96 |
|----------------|-------|--------|--------|--------|--------|--------|--------|--------|--------|--------|

**Task**

PPS uses alerts and secure messaging functionality.

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<th>Project Requirements (Milestone/Task Name)</th>
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<tbody>
<tr>
<td>Task 1 Partner with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.</td>
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<td>Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.</td>
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<tr>
<td>Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.</td>
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<td>Task 4 Develop other interim solutions for sharing health information among clinical partners using direct eXpatient record lookup. Determine other needs or enhancements based on IT/integration gap analyses. 04/01/2015-12/31/2015</td>
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<td>Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.</td>
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<td>Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.</td>
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<td>Task 7 Develop final plan for sharing health information among clinical partners by DY3.</td>
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<td>Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.</td>
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<tr>
<td>Milestone #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.</td>
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<td>Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
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<td>Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
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## Project Requirements
(Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
**Task**
1. Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.

2. Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based on the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).

3. Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.

4. Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.

**Milestone #4**
Use EHRs or other technical platforms to track all patients engaged in this project.

**Task**
PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

1. Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home-grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.

2. Create "how to" training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.

3. Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as BP levels,
### Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.

**Milestone #5**  
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).

**Task**  
PPS has implemented an automated scheduling system to facilitate tobacco control protocols.

**Task**  
PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.

**Task**  
1 Organize tobacco assessment tools within the EMR and create mandatory fields where the provider is prompted and obligated to record tobacco use assessment and counseling for users. Leverage meaningful use requirements and systems to assist in these prompts.

**Task**  
2 Create evidence based protocols for tobacco use cessation incorporating the 5 A's.

**Task**  
3 Distribute protocols and train practices on documentation and process within the protocols and how to use the assessment tools. Protocol shall be distributed in physician engagement meetings, by provider engagement team, and in electronic forms. Provider engagement teams will provide training on processes and implementation to these at onsite visits and trainings. The provider engagement team visits will be ongoing and used to provide periodic trainings and updates on protocols, processes and updates.

**Milestone #6**  
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.

**Task**  
Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).

**Task**  
1 Develop/create evidence based protocols for Cardio vascular disease to include evaluation and treatment of hyperlipidemia as approved by ACP physician leads in accordance with JNC-8, American Heart Association, and USPSTF.
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<th>Project Requirements (Milestone/Task Name)</th>
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<td>2 Leverage existing physician groups to reach and obtain “buy in” of physician partners in ACP protocols and processes.</td>
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<td>3 Use provider engagement teams, physician engagement meetings, Care Teams to establish rapport with providers and distribute and train in the adoption of the evidence based protocols and standards of care.</td>
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<td>4 ACP has provider participation agreements in place with its providers in which there is an acceptance as to following ACP processes including standards of care and metric reporting.</td>
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<td>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.</td>
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<td>Clinically Interoperable System is in place for all participating providers.</td>
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<td>Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
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<td>Care coordination processes are in place.</td>
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<tr>
<td>1 Establish ACP PMO back office central hub which includes team of care coordinators, care managers, community health workers, outreach staff.</td>
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<td>2 Create training materials for patient education and self-management in different languages taking into consideration the language and culture of the target population.</td>
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<td>4 Train back office staff in ACP care coordination processes in accordance with project requirements and project specific protocol implementation.</td>
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<td>5 Train back office staff, care managers, care coordinators in patient self-management techniques as per the ACP created and disseminated patient self-management training materials.</td>
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# Project Requirements

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<tr>
<td><strong>Staff will learn what the coordination requirements are as per the established protocols and ACP processes. They will learn Implementation of protocol specific techniques in language and culturally appropriate manner.</strong></td>
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<td><strong>Establish Care Teams ensuring inclusion of pharmacists, nutritional counselors, and other ancillary providers including DME vendors, diagnostic entities, etc. that back office will coordinate</strong></td>
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<td><strong>Train back office staff care managers and care coordinators in lifestyle coaching and providing educational materials in language appropriate and culturally sensitive manner</strong></td>
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<td><strong>Train and utilize Community health workers to approach and educate target populations to increase health literacy, self awareness and disease management and prevention.</strong></td>
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<td><strong>Utilize community health workers to liaise with CBOs to hold Stanford Model educational seminars within the communities in a culturally sensitive and language appropriate forum.</strong></td>
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<td><strong>Implement IDS consistent with project 2.a.i to have a integration of information centralized and accessible for more efficient and effective care. The IDS will utilize interfaces and connections for two way interchange of information between physician EMRs, hospital EMRs, CBOs and other entities all of which the central Care coordination teams will be able to access for follow up and follow through.</strong></td>
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<td><strong>Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</strong></td>
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<td><strong>All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.</strong></td>
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<td><strong>As required in ACP's protocol and processes, agreements are made with all PCPs that provide for the opportunity for patients to have BP monitored as walk ins, without appointments and without copay.</strong></td>
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<td><strong>PPS negotiates with MCOs to assure that no copays are deemed necessary for BP checks.</strong></td>
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<td><strong>Process and procedure manual and agreement with PCPs to</strong></td>
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also stipulate need to fit patient into schedule to be seen by provider if BP values are at unacceptable levels.

Milestone #9
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.

Task
PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.

Task
1 Develop training manuals for training of office staff at all levels on proper technique and equipment use for accurate BP measurement. Training manual also to include acceptable and non-acceptable values, to prompt staff to seek physician intervention upon attainment of unacceptable values.

Task
2 Implement training to all staff regarding BP measurement. Provider engagement teams provide on-site training to practice staff on BP measurement manual and obtain staff training certifications to be provided to Workforce office for monitoring and reporting.

Milestone #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.

Task
PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.

Task
PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.

Task
PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.

Task
1 Develop data pull frequencies to utilize EMR patient registries to identify blood-pressure values.

Task
2 Create analytics tool to cross analyze BP values against those with Cardiovascular diagnosis, ie diagnosis of Hypertension and number of encounters with elevated blood-pressure values.

Task
3 Create process for reporting to Central hub and to PCP
### Project Requirements (Milestone/Task Name)

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<td><strong>Task 4</strong>  Create process for receiving patient data for those identified via the data analysis and providing outreach to these patients to schedule for PCP visit and early intervention. Outreach may be provided at the central level via community health workers if needed or at the local level by the PCP office when patient is reachable and known to them.</td>
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<td><strong>Task 5</strong>  Processes for identification and periodicity of visits to be updated periodically, and minimally yearly by Clinical Quality Committee and staff retraining to be repeated as necessary, minimally yearly to keep up to date on process updates.</td>
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<td><strong>Milestone #11</strong>  Prescribe once-daily regimens or fixed-dose combination pills when appropriate.</td>
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<td><strong>Task</strong>  PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.</td>
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<td><strong>Task 1</strong>  Implement ACP evidence based CV protocol created in accordance with JNC recommendations, which calls for once daily regimens and includes preferential drugs as appropriate in a format that is user friendly and understandable.</td>
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<td><strong>Task 2</strong>  Train physicians on implementation of evidence based protocols treatment plans and provide assistance and follow up.</td>
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<td><strong>Task 3</strong>  Clinical Quality Committee Review CV evidence based protocols periodically and minimally yearly to revise and update as per latest advances and recommendations.</td>
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<td><strong>Milestone #12</strong>  Document patient driven self-management goals in the medical record and review with patients at each visit.</td>
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<td><strong>Task</strong>  Self-management goals are documented in the clinical record.</td>
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<td><strong>Task</strong>  PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.</td>
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<td><strong>Task 1</strong>  As per evidence based protocols, train providers on setting self-management goals for the individual patient. Self-management goals may be updated as per updated protocols.</td>
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<td>upon review by the Clinical Quality Committee.</td>
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<td><strong>Task</strong></td>
<td>2 Provide training to staff on monitoring the patient's progress on self-management goal as per set goals according to protocols. Re-Training will be periodic and minimally yearly, though may be sooner if protocol needs updating.</td>
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<td><strong>Task</strong></td>
<td>3 Work with EMR vendors to Create and Provide structured data fields within the EMRs where self-management goals can be easily identified and progress on such can be reportable.</td>
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<td><strong>Task</strong></td>
<td>4 Train providers and staff on entering self-management goals data entering and monitoring.</td>
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<td><strong>Milestone #13</strong></td>
<td>Follow up with referrals to community based programs to document participation and behavioral and health status changes.</td>
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<td><strong>Task</strong></td>
<td>PPS has developed referral and follow-up process and adheres to process.</td>
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<td><strong>Task</strong></td>
<td>PPS provides periodic training to staff on warm referral and follow-up process.</td>
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<td><strong>Task</strong></td>
<td>Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.</td>
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<td><strong>Task</strong></td>
<td>1 Engage PCPs and train on and implement cardiovascular (CV) evidence based protocols ensuring attention to identification of behavioral health status and referral criteria.</td>
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<td><strong>Task</strong></td>
<td>2 Create protocol and processes for realization of “warm handoffs” when patients identified as needing behavioral health services. Utilize physician engagement team to implement and train staff at PCP office on “warm handoffs” of patients needing behavioral health services.</td>
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<td><strong>Task</strong></td>
<td>3 Provide PCPs with care teams' information and referral processes for providing referrals to and receiving information from CBOs, Behavioral and Mental health partners.</td>
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<td><strong>Task</strong></td>
<td>4 Establish central back office inclusive of care coordinators, care managers, community health workers and outreach staff</td>
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## Project Requirements

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<td>with interfaces and two way connections that allow for upload of referrals as they are created by partners and as they are processed.</td>
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<td><strong>Task 5</strong> Establish and implement processes by which care coordinators receive and follow referrals as they are uploaded into Care management system electronically.</td>
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<td><strong>Task 6</strong> Establish and implement process and procedures by which care coordinators intervene in assisting patients in coordinating needed services from the full range of ACP partner providers and community based organizations, local government and specialty agencies.</td>
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<td><strong>Task 7</strong> Establish process by which care coordinator central or at the practice site ensures receipt of services by patient and marks to send back to referring provider the result and outcome of services received by patient using.</td>
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<td><strong>Task 8</strong> Develop and implement procedures for warm handoffs as in previous tasks.</td>
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<td><strong>Task 9</strong> Establish periodicity of staff retraining to ensure comprehension and adherence to processes. Retraining to be minimally yearly but optimally twice yearly.</td>
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<td><strong>Task 10</strong> Perform analysis of CNA to determine community resources available.</td>
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<td><strong>Task 11</strong> Perform network analysis to determine size and scope of necessary resources</td>
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<td><strong>Task 12</strong> Draft CBO agreements and present to Board for approval. The CBO agreements will include services to be provided, timeliness of provision of services, ability and commitment to timely information exchange.</td>
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<td><strong>Task 13</strong> Utilize Community Engagement teams to Distribute RFP to CBOs to evaluate services, timeliness of services and CBO’s capacity.</td>
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<td><strong>Task 14</strong> Utilize Community Engagement team to establish rapport, present formal agreements and obtain signed formal agreements.</td>
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<td>Develop and implement protocols for home blood pressure monitoring with follow up support.</td>
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<td>PPS has developed and implemented protocols for home blood pressure monitoring.</td>
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<td>PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.</td>
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<td>PPS provides periodic training to staff on warm referral and follow-up process.</td>
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<td>Develop training manual for patients on how to measure BP. The manual includes proper technique and equipment use. The manual also contains guidance on values and goals with instruction on alert values and how to document the values.</td>
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<td>Distribute BP manual to all practices for implementation and release to patients.</td>
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<td>Engage physicians and their staff in implementation of manual and training the patient. The physician engagement team shall provide in-house training to physicians and all practice staff on how to use the training manual and how to train the patient on proper BP measuring.</td>
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<td>Processes are put in place at PCP offices for staff to accept and evaluate patient's BP logs which the patient shall bring to every visit.</td>
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<td>Staff is trained as per BP manual on evaluating equipment. BP levels measured at PCP office with patient equipment may be compared to readings at PCP office using office equipment.</td>
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<td>Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<td>PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<td>Establish process for monthly data pulls from EMR registries for all patients with Hypertensive Cardiovascular disease by ICD code</td>
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</tr>
</thead>
<tbody>
<tr>
<td>2 Create filters for cross reference of reports pulled from EMR registries with parameters for all patients with hypertensive CV disease by ICD code/ date of last encounter/ and date of next visit. Identify all patients without a follow up appointment or who skipped a scheduled encounter.</td>
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<tr>
<td>3 Establish process for outreach to target patients and schedule a prompt appointment. PCPs allow for timely scheduling of the appointments.</td>
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<tr>
<td>4 Establish process for staff to communicate to CHWs patient lists/rosters who miss more than one appointment or are not reachable. CHW will provide services within the community and work to find the patient and connect the patient back to the PCP.</td>
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<tr>
<td>Milestone #16 Facilitate referrals to NYS Smoker's Quitline.</td>
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<tr>
<td>Task 1 Establish procedures in accordance with evidence based protocols for referrals of tobacco users to NYS Smoker's Quitline.</td>
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<tr>
<td>2 Implement process for care coordinators and CHWs to receive and access referrals and follow up to ensure compliance and assist in care plan.</td>
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<tr>
<td>Milestone #17 Perform additional actions including &quot;hot spotting&quot; strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.</td>
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<tr>
<td>Task 1 If applicable, PPS has implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.</td>
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<tr>
<td>Task 2 If applicable, PPS has established linkages to health homes for targeted patient populations.</td>
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<td>Task 3 If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.</td>
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## Project Requirements (Milestone/Task Name)

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<th>DY4,Q3</th>
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<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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<tbody>
<tr>
<td>1 Perform CNA analysis to determine &quot;hot spots&quot;. Determine neighborhoods with highest risk.</td>
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<tr>
<td>2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.</td>
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<tr>
<td>3 Utilize EMR technology to gather pertinent information. Activate features within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.</td>
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<tr>
<td>4 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.</td>
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<tr>
<td>5 As in previous tasks, Utilize community health workers to identify and establish agreements with CBOs that will then serve for implementation of Stanford model.</td>
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### Milestone #18

**Adopt strategies from the Million Hearts Campaign.**

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<tr>
<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
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<tr>
<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
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<tr>
<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
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### Task

1. With physician leads, Create ACP Million Hearts Campaign implementation and training materials.
2. Distribute Million Hearts Campaign implementation materials to all PCPs at physician engagement meetings, in person by Physician engagement team member, electronically.
3. Physician engagement team to provide PCPs training on
### Project Requirements (Milestone/Task Name)

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<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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<tr>
<td>million hearts campaign implementation to include BP checks without appointments, without copays, staff training and re-training and identifying a designated BP check area.</td>
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<tr>
<td><strong>Task 4</strong> Working with community enterprises, organizations, MCOs and Physicians; ACP’s Community Engagement team will negotiate and create patient compliance incentives to assist in motivating patients to adhere to treatment plans</td>
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<tr>
<td><strong>Task 5</strong> Develop processes in accordance with million hearts campaign including patient self-management educational materials to be distributed to target patients and training provided at point of care in provider office.</td>
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<tr>
<td><strong>Task 6</strong> Develop patient training and educational materials for patient disease self-management techniques including how to monitor and record blood pressure levels at home.</td>
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<td><strong>Task 7</strong> Develop Lifestyle modification teaching and training materials including nutritional counseling.</td>
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<tr>
<td><strong>Task 8</strong> In accordance with Million Hearts Campaign, Develop staff retraining tools and manuals and use provider engagement team to provide individual practice’s staff members retraining on how to monitor blood pressures to ensure that patients can walk in to the practice and have their BP checked by any staff member at any time. The process will ensure that each staff member knows the correct technique and value assessment at the time that the patient comes in and is trained on the process to bring out of range values to the immediate attention of the provider.</td>
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<tr>
<td><strong>Milestone #19</strong> Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.</td>
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<tr>
<td><strong>Task</strong> PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
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<tr>
<td><strong>Task</strong> Leverage existing relationships with MCOs to negotiate extended coverage for target and affected population. The negotiating to include coverage for items such as BP machines</td>
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NYS Confidentiality – High
### Project Requirements

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<th>DY5,Q2</th>
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<tr>
<td>for every patient with Hypertension, Nutritional counseling, smoking cessation medications and counseling as well as others.</td>
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<tr>
<td>Utilize existing relationships to negotiate and form agreements with MCOs by which copays are waived for BP check exams.</td>
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<tr>
<td>Engage a majority (at least 80%) of primary care providers in this project.</td>
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<tr>
<td>PPS has engaged at least 80% of their PCPs in this activity.</td>
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<tr>
<td>Leverage relationships within physician groups, IPAs, etc to engage physicians in ACP values.</td>
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<tr>
<td>Working with the finance department, formulate incentives for PCP participation.</td>
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<tr>
<td>Through physician engagement meetings, physician engagement teams, physician champions and other relationships; foster tight relationships with physicians and obtain agreements of participation with at least 80% of PCPs in ACP’s network.</td>
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### Prescribed Milestones Current File Uploads

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### Prescribed Milestones Narrative Text

<table>
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<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction...</td>
</tr>
<tr>
<td>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.</td>
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## Prescribed Milestones Narrative Text

<table>
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<tr>
<th>Milestone Name</th>
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<tbody>
<tr>
<td>Including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.</td>
<td>of the Speed and Scale commitments.</td>
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<tr>
<td>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.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
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<tr>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<td>Use the EHR to prompt providers to complete the 5 A’s of tobacco control (Ask, Assess, Advise, Assist, and Arrange).</td>
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<tr>
<td>Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.</td>
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<tr>
<td>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.</td>
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<tr>
<td>Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.</td>
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<tr>
<td>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.</td>
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<td>Prescribe once-daily regimens or fixed-dose combination pills when appropriate.</td>
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<td>Document patient driven self-management goals in the medical record and review with patients at each visit.</td>
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NYS Confidentiality – High
### Prescribed Milestones Narrative Text

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<tr>
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<tbody>
<tr>
<td>Follow up with referrals to community based programs to document participation and behavioral and health status changes.</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
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<tr>
<td>Develop and implement protocols for home blood pressure monitoring with follow up support.</td>
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<td>Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<tr>
<td>Facilitate referrals to NYS Smoker’s Quitline.</td>
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<tr>
<td>Perform additional actions including “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.</td>
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<tr>
<td>Adopt strategies from the Million Hearts Campaign.</td>
<td>Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.</td>
</tr>
<tr>
<td>Engage a majority (at least 80%) of primary care providers in this project.</td>
<td>Engage a majority (at least 80%) of primary care providers in this project.</td>
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NYS Confidentiality – High
### IPQR Module 3.b.i.5 - PPS Defined Milestones

**Instructions:**

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

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<th>Description</th>
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<th>End Date</th>
<th>Quarter End Date</th>
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IPQR Module 3.b.i.6 - IA Monitoring

Instructions:

Milestone 6: The IA recommends adopting evidenced based guidelines already in the public domain for Task # 1 as opposed to develop and/or creating your own.
Project 3.c.i – Evidence-based strategies for disease management in high risk/affected populations (adults only)

Instructions:

Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

ACP sees the following two major risks:

1. Based on customs and culture. The ACP PPS providers serve ethnic populations that are accustomed to high carbohydrate diets, and have low education and health literacy rates. Changing eating patterns that are passed from generation to generation will represent a great challenge for the PPS. To meet this challenge the PPS plans to leverage its cultural diversity and the integration of its culturally aligned providers to reach not only the patient in a language and tone that they can understand and accept, but also to reach the families and caregivers of these patients who are many times responsible for providing for the needs of the patient. The PPS will also provide education at the Primary Care level with regard to disease, disease prevention and disease management, directly one on one, and through educational materials/handouts and via the website and population wide campaigns.

2. Changing the mechanics of a primary care office which is already stressed and overworked and will now have to incorporate more teaching time. The PPS plans to meet this challenge by providing strong support and training to all staff so that there is not just one or two people available, but rather any available staff member may provide the needed service. ACP will create the educational materials and have a communications and outreach team put together patient incentives. The PPS will also negotiate with MCOs to cover the full cost of blood pressure for all patients with hypertension in any of its forms.
### IPQR Module 3.c.i.2 - Project Implementation Speed

**Instructions:**

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.

Note: data entered into this table must represent CUMULATIVE figures.

#### Benchmarks

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>549</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>1,428</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Clinics</td>
<td>43</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Health Home / Care Management</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>130</td>
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<td>0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>34</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Pharmacies</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>1,418</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>3,632</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent Committed Providers(%)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**NYS Confidentiality – High**
Advocate Community Providers, Inc.  (PPS ID:25)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse</td>
<td>34</td>
<td>DY3,Q3 24</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>6</td>
<td>DY3,Q3 6</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>15</td>
<td>DY3,Q3 15</td>
</tr>
<tr>
<td>All Other</td>
<td>1,418</td>
<td>DY3,Q3 1,418</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>3,632</td>
<td>DY3,Q3 2,547</td>
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<tr>
<td>Percent Committed Providers(%)</td>
<td>70.13</td>
<td>DY3,Q3 100.00</td>
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Current File Uploads

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<thead>
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<th>File Name</th>
<th>File Description</th>
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</thead>
</table>

No Records Found

Narrative Text:

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
IPQR Module 3.c.i.3 - Patient Engagement Speed

Instructions:
Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.
Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Year, Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>78,062</td>
<td>94,790</td>
<td>111,517</td>
<td>50,740</td>
<td>144,972</td>
<td>184,001</td>
<td>223,035</td>
<td>50,740</td>
<td>100,365</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>0.00</td>
<td>35.00</td>
<td>42.50</td>
<td>50.00</td>
<td>22.75</td>
<td>65.00</td>
<td>82.50</td>
<td>100.00</td>
<td>22.75</td>
<td>45.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year, Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>184,001</td>
<td>223,035</td>
<td>50,740</td>
<td>144,972</td>
<td>184,001</td>
<td>223,035</td>
<td>50,740</td>
<td>144,972</td>
<td>184,001</td>
<td>223,035</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>82.50</td>
<td>100.00</td>
<td>22.75</td>
<td>65.00</td>
<td>82.50</td>
<td>100.00</td>
<td>22.75</td>
<td>65.00</td>
<td>82.50</td>
<td>100.00</td>
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Current File Uploads

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<tr>
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<tbody>
<tr>
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</table>

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In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
## New York State Department Of Health

**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**

**Advocate Community Providers, Inc. (PPS ID:25)**

### IPQR Module 3.c.i.4 - Prescribed Milestones

**Instructions:**

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

<table>
<thead>
<tr>
<th>Milestone #1</th>
<th>Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task</strong></td>
<td>Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.</td>
</tr>
<tr>
<td><strong>Provider Type</strong></td>
<td>Project</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>In Progress</td>
</tr>
<tr>
<td><strong>Start Date</strong></td>
<td>04/01/2015</td>
</tr>
<tr>
<td><strong>End Date</strong></td>
<td>03/31/2018</td>
</tr>
<tr>
<td><strong>Quarter End Date</strong></td>
<td>03/31/2018</td>
</tr>
<tr>
<td><strong>DSRIP Reporting Year and Quarter</strong></td>
<td>DY3 Q4</td>
</tr>
</tbody>
</table>

| Task 1 | In conjunction with physician leads who are endocrinologists and internists Develop evidence based protocols in accordance with ADA guidelines for evaluation and treatment of patients with Diabetes. |
| **Provider Type** | Project |
| **Status**  | Completed |
| **Start Date** | 04/01/2015 |
| **End Date** | 06/30/2015 |
| **Quarter End Date** | 06/30/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q1 |

| Task 2 | Disseminate and Implement protocols and procedures to physicians via physician engagement meetings, on site trainings and electronic format. |
| **Provider Type** | Project |
| **Status**  | Completed |
| **Start Date** | 04/01/2015 |
| **End Date** | 06/30/2015 |
| **Quarter End Date** | 06/30/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q1 |

| Task 3 | Based on protocol guidelines for evaluation, create a reporting system for using EMR registries to identify target patients, ie. HgbA1C, Kidney Function, Cholesterol levels. |
| **Provider Type** | Project |
| **Status**  | In Progress |
| **Start Date** | 04/01/2015 |
| **End Date** | 09/30/2015 |
| **Quarter End Date** | 09/30/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q2 |

| Task 4 | Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and educational services as needed |
| **Provider Type** | Project |
| **Status**  | In Progress |
| **Start Date** | 04/01/2015 |
| **End Date** | 09/30/2015 |
| **Quarter End Date** | 09/30/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q2 |

| Task 5 | Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members. Protocols are also be made distributed electronically to every provider. |
| **Provider Type** | Project |
| **Status**  | Completed |
| **Start Date** | 04/01/2015 |
| **End Date** | 06/30/2015 |
| **Quarter End Date** | 06/30/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q1 |

| Task 6 | Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR. |
| **Provider Type** | Project |
| **Status**  | Completed |
| **Start Date** | 04/01/2015 |
| **End Date** | 06/30/2015 |
| **Quarter End Date** | 06/30/2015 |
| **DSRIP Reporting Year and Quarter** | DY1 Q1 |
## Project Requirements

| Task                                                                 | Reporting Level | Provider Type               | Status        | Start Date | End Date | Quarter End Date | DSRI  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.</td>
<td>Project</td>
<td></td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td>8 Employ physician engagement teams to hand deliver protocols and process and procedure manuals to providers and office staff and provide training on implementation processes.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>PPS has engaged at least 80% of their PCPs in this activity.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>1 Leverage physician groups such as IPAs, physician champions, Hospital partners, etc. in to engage PCPs in the implementation of the project.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>2 Physician engagement team members to visit all PCPs provide assistance and training. Through onsite visits and their one on one interactions foster relationships, provide assistance and training and obtain further commitments from PCPs toward the achievement of the 80% participation.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>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.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Clinically Interoperable System is in place for all participating providers.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Care coordination processes are established and implemented.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>1 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Project</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc. (PPS ID:25)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task 3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, diabetic educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task 4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Milestone #4 Develop &quot;hot spotting&quot; strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task If applicable, PPS has established linkages to health homes for targeted patient populations.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 1 Perform CNA analysis to determine &quot;hot spots&quot;. Determine neighborhoods with highest risk.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 3 Utilize EMR technology to gather pertinent information. Activate features</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

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<tr>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>4 Utilize REAL data provided in EMR to arrange Stanford Model activities in location, language and culture of the population to be addressed.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
</tr>
<tr>
<td>Task</td>
<td>5 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
</tr>
<tr>
<td>Milestone #5</td>
<td>Ensure coordination with the Medicaid Managed Care organizations serving the target population.</td>
<td>Project</td>
<td>N/A</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
</tr>
<tr>
<td>Task</td>
<td>PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
</tr>
<tr>
<td>Task</td>
<td>1 Leverage existing relationships between physician groups and MCOs to bring to the table MCO executives for contract negotiations with ACP.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
</tr>
<tr>
<td>Task</td>
<td>2 Produce reports with comparison analytic data on healthcare costs for complicated Diabetes patients versus ROI when preventative care is provided from onset of diabetes and throughout.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
</tr>
<tr>
<td>Task</td>
<td>3 Leverage analytic data to negotiate on behalf of ACP patients to obtain extension of coverage for evidence based prescribed preventive services. Service to include eye and vision screening, smoking cessation therapy, Cardiovascular disease evaluation, periodic preventive Renal function testing, and several others.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
</tr>
<tr>
<td>Milestone #6</td>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>06/30/2016</td>
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<tr>
<td>Task</td>
<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
</tr>
<tr>
<td>Task</td>
<td>PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
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NYS Confidentiality – High
## Project Requirements Table

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
<td>of needed services.</td>
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<td><strong>Task 1</strong> Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
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<td>DY1 Q4</td>
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<tr>
<td><strong>Task 2</strong> Create “how to” training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td><strong>Task 3</strong> Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as HgbA1C levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task 4</strong> ACP will leverage existing EMR systems and create recall criteria to ensure that all patients are tracked and receive services timely. The criteria will include laboratory data such as last HgbA1c, visit data such as last visit, last comprehensive preventive physical, last eye exam and other criteria. Periodicity will vary depending on service.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
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<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Milestone #7</strong> 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.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td><strong>Task</strong> PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
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<td>04/01/2015</td>
<td>03/31/2018</td>
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<td>DY3 Q4</td>
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<tr>
<td>EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
<td>Provider Safety Net Non-PCP Practitioners</td>
<td>In Progress</td>
<td>04/01/2015</td>
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<tr>
<td>EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
<td>Provider Safety Net Behavioral Health</td>
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<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<th>DY2,Q4</th>
<th>DY3,Q1</th>
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<tr>
<td>Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.</td>
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<tr>
<td>Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.</td>
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<tr>
<td>In conjunction with physician leads who are endocrinologists and internists Develop evidence based protocols in accordance with ADA guidelines for evaluation and treatment of patients with Diabetes.</td>
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<tr>
<td>Disseminate and Implement protocols and procedures to physicians via physician engagement meetings, on site</td>
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<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tr>
<td>Trainings and electronic format.</td>
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<tr>
<td>Task 3 Based on protocol guidelines for evaluation, create a reporting system for using EMR registries to identify target patients, ie. HgbA1C, Kidney Function, Cholesterol levels.</td>
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<tr>
<td>Task 4 Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and educational services as needed</td>
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<tr>
<td>Task 5 Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members. Protocols are also be made distributed electronically to every provider.</td>
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<tr>
<td>Task 6 Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.</td>
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<tr>
<td>Task 7 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.</td>
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<tr>
<td>Task 8 Employ physician engagement teams to hand deliver protocols and process and procedure manuals to providers and office staff and provide training on implementation processes.</td>
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</tbody>
</table>

### Milestone #2

**Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.**

**Task 1** PPS has engaged at least 80% of their PCPs in this activity.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>55</th>
<th>165</th>
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<th>329</th>
<th>384</th>
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</tr>
</thead>
</table>

**Task 2** Leverage physician groups such as IPAs, physician champions, Hospital partners, etc. in to engage PCPs in the implementation of the project.

**Task 3** Physician engagement team members to visit all PCPs provide assistance and training. Through onsite visits and their one on one interactions foster relationships, provide assistance.
and training and obtain further commitments from PCPs toward the achievement of the 80% participation.

Milestone #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.

Task
Clinically Interoperable System is in place for all participating providers.

Task
Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.

Task
Care coordination processes are established and implemented.

Task
1 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.

Task
2 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.

Task
3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, diabetic educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.

Task
4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP’s central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.

Milestone #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.
### Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Task</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
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<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>If applicable, PPS has implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.</td>
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<tr>
<td>If applicable, PPS has established linkages to health homes for targeted patient populations.</td>
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<tr>
<td>If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.</td>
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<tr>
<td>1 Perform CNA analysis to determine &quot;hot spots&quot;. Determine neighborhoods with highest risk.</td>
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<tr>
<td>2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.</td>
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<tr>
<td>3 Utilize EMR technology to gather pertinent information. Activate features within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.</td>
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<td>4 Utilize REAL data provided in EMR to arrange Stanford Model activities in location, language and culture of the population to be addressed.</td>
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<tr>
<td>5 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.</td>
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<tr>
<td>Ensure coordination with the Medicaid Managed Care organizations serving the target population.</td>
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<tr>
<td>PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
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<tr>
<td>Leverage existing relationships between physician groups and MCOs to bring to the table MCO executives for contract</td>
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**Milestone #5**

Ensure coordination with the Medicaid Managed Care organizations serving the target population.
## Advocate Community Providers, Inc. (PPS ID: 25)

<table>
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<th>Project Requirements (Milestone/Task Name)</th>
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<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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</thead>
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<tr>
<td>negotiations with ACP.</td>
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<tr>
<td><strong>Task</strong> 2 Produce reports with comparison analytic data on healthcare costs for complicated Diabetes patients versus ROI when preventative care is provided from onset of diabetes and throughout.</td>
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<td><strong>Task</strong> 3 Leverage analytic data to negotiate on behalf of ACP patients to obtain extension of coverage for evidence based prescribed preventive services. Service to include eye and vision screening, smoking cessation therapy, Cardiovascular disease evaluation, periodic preventive Renal function testing, and several others.</td>
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<td><strong>Milestone #</strong> Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<tr>
<td><strong>Task</strong> PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td><strong>Task</strong> PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.</td>
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<td><strong>Task</strong> 1 Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.</td>
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<td>Lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.</td>
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<td>4 ACP will leverage existing EMR systems and create recall criteria to ensure that all patients are tracked and receive services timely. The criteria will include laboratory data such as last HgbA1c, visit data such as last visit, last comprehensive preventive physical, last eye exam and other criteria. Periodicity will vary depending on service.</td>
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<tr>
<td>Milestone #7</td>
<td>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.</td>
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<td>Task</td>
<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
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<td>Task</td>
<td>PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
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<td>Task</td>
<td>EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
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<td>Task</td>
<td>EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
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<tr>
<td>Task</td>
<td>EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
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<td>Task</td>
<td>Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.</td>
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<td>Task</td>
<td>Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).</td>
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<td>Task</td>
<td>Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.</td>
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<td>Task</td>
<td>Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs.</td>
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NYS Confidentiality – High
## Project Requirements

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<th>DY3,Q2</th>
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<tr>
<td><em>Support may include internal or external resources.</em></td>
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### Milestone #1

Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.

**Task**

Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.

**Task**

1. In conjunction with physician leads who are endocrinologists and internists, develop evidence-based protocols in accordance with ADA guidelines for evaluation and treatment of patients with Diabetes.

**Task**

2. Disseminate and implement protocols and procedures to physicians via physician engagement meetings, on-site trainings, and electronic format.

**Task**

3. Based on protocol guidelines for evaluation, create a reporting system for using EMR registries to identify target patients, i.e., HgA1C, Kidney Function, Cholesterol levels.

**Task**

4. Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs, and promoting referral for behavioral health and social and educational services as needed.

**Task**

5. Disseminate evidence-based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members. Protocols are also made distributed electronically to every provider.

**Task**

6. Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.

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_NYS Confidentiality – High_
## Project Requirements (Milestone/Task Name)

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<tr>
<th>Task</th>
<th>DY3,Q3</th>
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<tr>
<td>7 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.</td>
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<td>8 Employ physician engagement teams to hand deliver protocols and process and procedure manuals to providers and office staff and provide training on implementation processes.</td>
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<td>Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.</td>
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<tr>
<td>PPS has engaged at least 80% of their PCPs in this activity.</td>
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<tr>
<td>1 Leverage physician groups such as IPAs, physician champions, Hospital partners, etc. in to engage PCPs in the implementation of the project.</td>
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<td>2 Physician engagement team members to visit all PCPs provide assistance and training. Through onsite visits and their one on one interactions foster relationships, provide assistance and training and obtain further commitments from PCPs toward the achievement of the 80% participation.</td>
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<tr>
<td>Milestone #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.</td>
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<td>Clinically Interoperable System is in place for all participating providers.</td>
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<td>Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
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<td>Care coordination processes are established and implemented.</td>
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<td>1 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.</td>
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**NYS Confidentiality – High**
### New York State Department Of Health
### Delivery System Reform Incentive Payment Project
### DSRIP Implementation Plan Project

**Advocate Community Providers, Inc.  (PPS ID:25)**

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>DY3,Q4</th>
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<td>2 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.</td>
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<tr>
<td>3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, diabetic educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.</td>
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<tr>
<td>4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.</td>
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<td>Develop “hot spotting” strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.</td>
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<td>If applicable, PPS has implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.</td>
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<td>If applicable, PPS has established linkages to health homes for targeted patient populations.</td>
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<td>If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.</td>
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<tr>
<td>1 Perform CNA analysis to determine &quot;hot spots&quot;. Determine neighborhoods with highest risk.</td>
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<tr>
<td>2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.</td>
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<tr>
<td>3 Utilize EMR technology to gather pertinent information.</td>
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NYS Confidentiality – High
## Project Requirements

**Project Requirements**

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<th>(Milestone/Task Name)</th>
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<th>DY5,Q3</th>
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<tbody>
<tr>
<td>Activate features within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.</td>
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<td>Task 4 Utilize REAL data provided in EMR to arrange Stanford Model activities in location, language and culture of the population to be addressed.</td>
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<td>Task 5 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.</td>
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<td>Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.</td>
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<td>Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
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<td>Task 1 Leverage existing relationships between physician groups and MCOs to bring to the table MCO executives for contract negotiations with ACP.</td>
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<td>Task 2 Produce reports with comparison analytic data on healthcare costs for complicated Diabetes patients versus ROI when preventative care is provided from onset of diabetes and throughout.</td>
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<tr>
<td>Task 3 Leverage analytic data to negotiate on behalf of ACP patients to obtain extension of coverage for evidence based prescribed preventive services. Service to include eye and vision screening, smoking cessation therapy, Cardiovascular disease evaluation, periodic preventive Renal function testing, and several others.</td>
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<td>Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<td>Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td>Task PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track</td>
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<td>when and how patients were notified of needed services.</td>
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<tr>
<td>1 Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.</td>
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<tr>
<td>2 Create &quot;how to&quot; training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.</td>
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<tr>
<td>3 Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as HgbA1C levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.</td>
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<tr>
<td>4 ACP will leverage existing EMR systems and create recall criteria to ensure that all patients are tracked and receive services timely. The criteria will include laboratory data such as last HgbA1c, visit data such as last visit, last comprehensive preventive physical, last eye exam and other criteria. Periodicity will vary depending on service.</td>
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<tr>
<td><strong>Milestone #7</strong></td>
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<tr>
<td>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.</td>
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<tr>
<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
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<tr>
<td>PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
<td>385</td>
<td>549</td>
<td>549</td>
<td>549</td>
<td>549</td>
<td>549</td>
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<td>549</td>
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<td>NYS Confidentiality – High</td>
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</tbody>
</table>
Project Requirements

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
<td>348</td>
<td>496</td>
<td>496</td>
<td>496</td>
<td>496</td>
<td>496</td>
<td>496</td>
<td>496</td>
<td>496</td>
<td>496</td>
</tr>
<tr>
<td>Task EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
<td>68</td>
<td>96</td>
<td>96</td>
<td>96</td>
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</tbody>
</table>

Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2a.

Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based on the different levels (i.e., those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).

Establish communications/marketing plan and outreach to all ACP safety net providers that also identifies support resources.

Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.

Prescribed Milestones Current File Uploads

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
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</tbody>
</table>

Prescribed Milestones Narrative Text

- Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.

- Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction.

NYS Confidentiality – High
## Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop care coordination teams (including diabetes educators, nursing staff,</td>
<td>of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>behavioral health providers, pharmacy, community health workers, and Health</td>
<td></td>
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<tr>
<td>Home care managers) to improve health literacy, patient self-efficacy, and</td>
<td></td>
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<tr>
<td>patient self-management.</td>
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<tr>
<td>Develop “hot spotting” strategies, in concert with Health Homes, to implement</td>
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<td>programs such as the Stanford Model for chronic diseases in high risk</td>
<td></td>
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<tr>
<td>neighborhoods.</td>
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<tr>
<td>Ensure coordination with the Medicaid Managed Care organizations serving the</td>
<td></td>
</tr>
<tr>
<td>target population.</td>
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</tr>
<tr>
<td>Use EHRs or other technical platforms to track all patients engaged in this</td>
<td></td>
</tr>
<tr>
<td>project.</td>
<td></td>
</tr>
<tr>
<td>Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS’s provider roster on the ramp up and satisfaction of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Demonstration Year 3 for EHR systems used by participating safety net providers.</td>
<td></td>
</tr>
</tbody>
</table>
### Checklists

**IPQR Module 3.c.i.5 - PPS Defined Milestones**

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRI</th>
<th>Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

**PPS Defined Milestones Current File Uploads**

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
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</thead>
<tbody>
<tr>
<td>No Records Found</td>
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</table>

**PPS Defined Milestones Narrative Text**

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>No Records Found</td>
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</tbody>
</table>
IPQR Module 3.c.i.6 - IA Monitoring
Instructions:

NYS Confidentiality – High
Project 3.d.iii – Implementation of evidence-based medicine guidelines for asthma management

- IPQR Module 3.d.iii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions:
Please describe what the major risks are for this project, as well as the actions you plan to take to mitigate them.

Major risks to implementation revolve around ascertaining environmental risk factor and trigger information and taking action to reduce or eliminate these. Many of the patients served by ACP are of Low Socio-economic status and have low health literacy rates. They may be accustomed to living conditions and environmental conditions that they believe to be normal or non-changeable and thus fail to report these. Asthma is a disease with high sensitivity to environmental factors. ACP plans to mitigate this risk by fostering tight bonds between the patient and the PCP so as to create and maintain open honest lines of communication. ACP will also provide the patients with health education both at the primary care setting as well as via the inclusion of CBOs to work with the patients and make them aware of disease management and prevention tools. ACP will also work closely with state and local departments to provide assistance with environmental hazards. ACP will also work closely with the Asthma coalition on patient education and attainment of services.

2. Another risk factor also related to health literacy but also involving other persons in contact with the patient revolves around schools, caregivers, and family members not knowing the appropriate action to take to help the asthmatic patient. ACP is implementing evidence based protocols and school/work and home/family Asthma action plans to better allow for the asthmatic patients to receive proper care in their current setting.
### IPQR Module 3.d.iii.2 - Project Implementation Speed

**Instructions:**

Please specify how many providers will have met all of the project requirements (as set out in the project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application.

Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>902</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>1,428</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinics</td>
<td>43</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>15</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>1,418</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>3,821</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent Committed Providers(%)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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</tbody>
</table>
Advocate Community Providers, Inc.  (PPS ID:25)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>DY3,Q3</td>
</tr>
<tr>
<td>Percent Committed Providers(%)</td>
<td>100.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Narrative Text:

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
Instructions:

Please specify how many patients will have become 'Actively Engaged' (as set out in the Project Plan Application) per quarter. These cumulative numbers must align with commitments in the PPS Application. Note: data entered into this table must represent CUMULATIVE figures.

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>33,839</td>
<td>59,219</td>
<td>84,599</td>
<td>29,610</td>
<td>84,599</td>
<td>126,899</td>
<td>169,199</td>
<td>29,610</td>
<td>76,139</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>0.00</td>
<td>20.00</td>
<td>35.00</td>
<td>50.00</td>
<td>17.50</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
<td>17.50</td>
<td>45.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>126,899</td>
<td>169,199</td>
<td>29,610</td>
<td>84,599</td>
<td>126,899</td>
<td>169,199</td>
<td>29,610</td>
<td>84,599</td>
<td>126,899</td>
<td>169,199</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>75.00</td>
<td>100.00</td>
<td>17.50</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
<td>17.50</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
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</tbody>
</table>

In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction of the Speed and Scale commitments.
IPQR Module 3.d.iii.4 - Prescribed Milestones

Instructions:

Please enter baseline target dates and work breakdown tasks with target dates for each of the milestones below.

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Task PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task All participating practices have a Clinical Interoperability System in place for all participating providers.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Task All participating practices have a Clinical Interoperability System in place for all participating providers.</td>
<td>Provider</td>
<td>Non-PCP Practitioners</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Task 1 Working with physician leads who are internists, pediatricians, pulmonologist and in accordance with NIH guidelines, develop evidence based protocols for evaluation and management of Asthma in adults and children.</td>
<td>Project</td>
<td>N/A</td>
<td>Completed</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td>Task 2 Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.</td>
<td>Project</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task 3 Develop processes for referrals as prescribed by evidence based protocol for referring patients to specialists and specialty services including community based organizations and programs. Process shall include care coordination by ACP's central back office care coordinator team.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 4 Obtain signed service agreements between ACP and participating providers.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task 5 Establish relationships and agreements with schools and other community based organizations and programs that can be a part of the ACP Care Teams.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Project Requirements (Milestone/Task Name)</td>
<td>Reporting Level</td>
<td>Provider Type</td>
<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
</tr>
<tr>
<td>------------------------------------------</td>
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<td>---------------------------------</td>
</tr>
<tr>
<td>provide necessary services to patients and assist/support in implementation of evidence based asthma management action plans.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 6 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 7 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 9 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<td>Task 8 Utilize EMR interfaces, data feeds, interconnectivity capabilities to connect all providers within the PPS to be able to have more immediate information exchange between partners.</td>
<td>Project</td>
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<td>01/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<td>Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Task Agreements with asthma specialists and asthma educators are established.</td>
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<td>12/31/2015</td>
<td>12/31/2015</td>
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<td>Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
<td>Provider Safety Net Primary Care Physicians</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<td>Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
<td>Provider Safety Net Non-PCP Practitioners</td>
<td>In Progress</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients</td>
<td>Project</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Advocate Community Providers, Inc.  (PPS ID:25)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
</table>
| - why telemedicine is the best alternative to provide these services  
- challenges expected and plan to pro-actively resolve  
- plan for long term sustainability | | | | | | | |
| **Task 1**  
Develop ACP participating provider service agreements. The agreement shall include provider commitment to adhering to ACP developed evidence based protocols and processes and obtain Board approval. | Project | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task 2**  
Distribute agreement and obtain signed commitment from all providers of all provider types to adhere to ACP evidence based protocols and processes. Obtaining signed agreements shall be a concerted effort on behalf of ACP and will leverage physician groups such as IPAs, as well as Hospital partner's relationships with providers in their area and physician engagement team. | Project | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task 3**  
Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, asthma educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management. | Project | In Progress | 10/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task 4**  
Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc. | Project | In Progress | 10/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Task 5**  
Develop telemedicine capabilities within the ACP central back office Care Coordination/ Care management. | Project | In Progress | 01/01/2016 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task 6**  
Review "hot spotting" results and CNA resource analysis, ACP network analysis and REAL data to target patients meeting those criteria for telemedicine and in the language and culturally sensitive manner as appropriate | Project | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3 |
| **Task 7**  
Perform analysis of accessibility of broadband services in areas where CNA analysis reveals the need to implement telemedicine to augment services and bridge gaps. | Project | In Progress | 10/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 |
| **Task 8**  
PPS to leverage Community Engagement team to negotiate with broadband service providers in areas where this service is necessary for population wide | Project | In Progress | 01/01/2016 | 09/30/2016 | 09/30/2016 | DY2 Q2 |

NYS Confidentiality – High
## Project Requirements

### Milestone #3
Deliver educational activities addressing asthma management to participating primary care providers.

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<tr>
<th>Task</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tr>
<td>Deliver educational activities addressing asthma management</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Participating providers receive training in evidence-based asthma management</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>12/31/2015</td>
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### Milestone #4
Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.

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<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tr>
<td>Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
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### Project N/A
PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with participating health home care managers, PCPs, and specialty providers.

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<tr>
<th>Task</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
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<tr>
<td>PPS has established agreements with MCOs that address the coverage of patients with asthma health issues</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
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<td>DY2 Q3</td>
</tr>
<tr>
<td>1 ACP will maintain close communications and information exchange with MCOs and Health Homes through direct feeds, referrals, data analysis and most over through these agency participation in the ACP Care Teams and PAC to ensure smooth coordination of care and creation of processes as necessary</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td></td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>2 Develop processes for identification of HH eligible patients, referral of these patients to HH and coordinating transition and care through HH</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
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<td>DY1 Q4</td>
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<tr>
<td>3 Establish ACP back office processes and procedures for coordinating care</td>
<td>Project</td>
<td>In Progress</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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Advocate Community Providers, Inc. (PPS ID:25)

### Project Requirements

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<th>End Date</th>
<th>Quarter End Date</th>
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</thead>
<tbody>
<tr>
<td>Task 4 Leverage existing relationships with MCOs to negotiate extended coverage for target and affected population. The negotiating to include coverage for items such as nebulizers for every patient with asthma, smoking cessation medications and counseling as well as others.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td>Task 5 Use EHRs or other technical platforms to track all patients engaged in this project.</td>
<td>Project</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Task 1 Incorporate Asthma action plans into the provider's EMR for ease of access, avoidance of duplication and tracking control.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>Task 2 Work with EMR vendors and IT departments to structure fields in which data is entered when patient is engaged and then extrapolated for tracking</td>
<td>Project</td>
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<td>09/30/2016</td>
<td>09/30/2016</td>
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<tr>
<td>Task 3 Utilize EMR's patient registries, MU dashboards, PCMH capabilities to obtain reports on patients engaged and those needing to be reached. Process will include filters by ICD and appointment date as well as other data useful in ascertaining patient compliance and health risk stratification and to identify target patients.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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</tr>
<tr>
<td>Task 4 Create processes and parameters within the EMRs that will also serve in the purpose of performance and compliance monitoring through flow sheets, interfaces with diagnostic entities to track disease progression efficacy of treatment, medication and dosing tracking, episode frequency and service utilization.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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<tr>
<td>Task 5 Create interconnectivity between provider EMRs the ACP platform, ACP will track Medication management, counseling, referrals and their completion.</td>
<td>Project</td>
<td>In Progress</td>
<td>01/01/2016</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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**Milestone #1 Implement evidence-based asthma management guidelines**

NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.</td>
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<tr>
<td>Task</td>
<td>PPS has agreements from participating providers and community programs to support evidence-based asthma management guidelines.</td>
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<tr>
<td>Task</td>
<td>All participating practices have a Clinical Interoperability System in place for all participating providers.</td>
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<td>180</td>
<td>586</td>
<td>902</td>
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<tr>
<td>Task</td>
<td>All participating practices have a Clinical Interoperability System in place for all participating providers.</td>
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<tr>
<td>Task</td>
<td>1 Working with physician leads who are internists, pediatricians, pulmonologist and in accordance with NIH guidelines, develop evidence based protocols for evaluation and management of Asthma in adults and children.</td>
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<tr>
<td>Task</td>
<td>2 Implement evidence-based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.</td>
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<tr>
<td>Task</td>
<td>3 Develop processes for referrals as prescribed by evidence based protocol for referring patients to specialists and specialty services including community based organizations and programs. Process shall include care coordination by ACP's central back office care coordinator team.</td>
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<tr>
<td>Task</td>
<td>4 Obtain signed service agreements between ACP and participating providers.</td>
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<tr>
<td>Task</td>
<td>5 Establish relationships and agreements with schools and other community based organizations and programs that can be a part of the ACP Care Teams, provide necessary services to patients and assist/support in implementation of evidence based asthma management action plans.</td>
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<tr>
<td>Task</td>
<td>6 Create IDS with two-way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.</td>
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<tr>
<td>Task</td>
<td>7 Develop a central care coordination/care management</td>
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NYS Confidentiality – High
## Project Requirements

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<th>DY1,Q2</th>
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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tr>
<td><strong>Task</strong> 8. Utilize EMR interfaces, data feeds, interconnectivity capabilities to connect all providers within the PPS to be able to have more immediate information exchange between partners.</td>
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<tr>
<td><strong>Task</strong> 9. Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP’s central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.</td>
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<tr>
<td><strong>Milestone #2</strong> Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.</td>
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<tr>
<td><strong>Task</strong> Agreements with asthma specialists and asthma educators are established.</td>
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<td><strong>Task</strong> Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability</td>
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<tr>
<td><strong>Task</strong> 1. Develop ACP participating provider service agreements. The agreement shall include provider commitment to adhering to ACP developed evidence based protocols and processes and</td>
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<td>obtain Board approval.</td>
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<td>2 Distribute agreement and obtain signed commitment from all providers of all provider types to adhere to ACP evidence based protocols and processes. Obtaining signed agreements shall be a concerted effort on behalf of ACP and will leverage physician groups such as IPAs, as well as Hospital partner's relationships with providers in their area and physician engagement team.</td>
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<tr>
<td>3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, asthma educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.</td>
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<tr>
<td>4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.</td>
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<tr>
<td>5 Develop telemedicine capabilities within the ACP central back office Care Coordination/ Care management.</td>
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NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

| Milestone #4 | Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population. |

#### Task

1. Develop user friendly versions of the protocol and processes.

2. Develop Asthma action plans for home work and school that can be incorporated into EMR for ease of access, efficient implementation for patient and tracking within the EMR system for tracking engagement and performance within the EMR.

3. Utilize physician engagement team to distribute process and procedure materials and provide on-site training on implementation of protocol and protocol processes at the providers office to providers and staff.

4. Leverage existing relationships with MCOs to negotiate

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#### Task

1. Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.

2. Develop evidence based protocol for the PPS providers.

---

### Milestone #4

**Asthma Management**

- Task 1: Implement Evidence-based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.

- Task 2: Develop user-friendly versions of the protocol and processes.

- Task 3: Develop Asthma action plans for home work and school that can be incorporated into EMR for ease of access, efficient implementation for patient and tracking within the EMR system for tracking engagement and performance within the EMR.

- Task 4: Utilize physician engagement team to distribute process and procedure materials and provide on-site training on implementation of protocol and protocol processes at the providers office to providers and staff.

---

**Milestones and Tasks**

- **Milestone #4**
  - Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.

- **Tasks**
  - 1. ACP will maintain close communications and information exchange with MCOs and Health Homes through direct feeds, referrals, data analysis and most over through these agency participation in the ACP Care Teams and PAC to ensure smooth coordination of care and creation of processes as necessary.
  
  - 2. Develop processes for identification of HH eligible patients, referral of these patients to HH and coordinating transition and care through HH.

  - 3. Establish ACP back office processes and procedures for coordinating care with MCOs obtaining necessary authorizations and fulfilling patient needs for services.

  - 4. Leverage existing relationships with MCOs to negotiate
extended coverage for target and affected population. The negotiating to include coverage for items such as nebulizers for every patient with asthma, smoking cessation medications and counseling as well as others.

Milestone #5
Use EHRs or other technical platforms to track all patients engaged in this project.

Task
PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.

Task
1. Incorporate Asthma action plans into the provider's EMR for ease of access, avoidance of duplication and tracking control.

Task
2. Work with EMR vendors and IT departments to structure fields in which data is entered when patient is engaged and then extrapolated for tracking.

Task
3. Utilize EMR's patient registries, MU dashboards, PCMH capabilities to obtain reports on patients engaged and those needing to be reached. Process will include filters by ICD and appointment date as well as other data useful in ascertaining patient compliance and health risk stratification and to identify target patients.

Task
4. Create processes and parameters within the EMRs that will also serve in the purpose of performance and compliance monitoring through flow sheets, interfaces with diagnostic entities to track disease progression efficacy of treatment, medication and dosing tracking, episode frequency and service utilization.

Task
5. Create interconnectivity between provider EMRs the ACP platform, ACP will track Medication management, counseling, referrals and their completion.

Project Requirements (Milestone/Task Name) | DY1,Q1 | DY1,Q2 | DY1,Q3 | DY1,Q4 | DY2,Q1 | DY2,Q2 | DY2,Q3 | DY2,Q4 | DY3,Q1 | DY3,Q2
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
Milestone #1
Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.

NYS Confidentiality – High
**Project Requirements (Milestone/Task Name)** | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4
---|---|---|---|---|---|---|---|---|---|---
**Task**<br>PSS has agreements from participating providers and community programs to support evidence-based asthma management guidelines.<br>902 902 902 902 902 902 902 902 902 902
**Task**<br>All participating practices have a Clinical Interoperability System in place for all participating providers.<br>1,428 1,428 1,428 1,428 1,428 1,428 1,428 1,428 1,428 1,428
**Task**<br>Working with physician leads who are internists, pediatricians, pulmonologist and in accordance with NIH guidelines, develop evidence based protocols for evaluation and management of Asthma in adults and children.<br>1 Working with physician leads who are internists, pediatricians, pulmonologist and in accordance with NIH guidelines, develop evidence based protocols for evaluation and management of Asthma in adults and children.<br>2 Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.<br>3 Develop processes for referrals as prescribed by evidence based protocol for referring patients to specialists and specialty services including community based organizations and programs. Process shall include care coordination by ACP's central back office care coordinator team.<br>4 Obtain signed service agreements between ACP and participating providers.<br>5 Establish relationships and agreements with schools and other community based organizations and programs that can be a part of the ACP Care Teams, provide necessary services to patients and assist/support in implementation of evidence based asthma management action plans.<br>6 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.<br>7 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.
### Project Requirements

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<td>8 Utilize EMR interfaces, data feeds, interconnectivity capabilities to connect all providers within the PPS to be able to have more immediate information exchange between partners.</td>
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<td>9 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP’s central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.</td>
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#### Milestone #2

Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.

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#### Task

- Agreements with asthma specialists and asthma educators are established.

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<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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#### Task

- Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to:
  - analysis of the availability of broadband access in the geographic area being served
  - gaps in services
  - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients
  - why telemedicine is the best alternative to provide these services
  - challenges expected and plan to pro-actively resolve
  - plan for long term sustainability

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#### Task

- Develop ACP participating provider service agreements. The agreement shall include provider commitment to adhering to ACP developed evidence based protocols and processes and obtain Board approval.

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#### Task

- Distribute agreement and obtain signed commitment from all providers of all provider types to adhere to ACP evidence

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**NYS Confidentiality – High**
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Advocate Community Providers, Inc. (PPS ID:25)

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based protocols and processes. Obtaining signed agreements shall be a concerted effort on behalf of ACP and will leverage physician groups such as IPAs, as well as Hospital partner’s relationships with providers in their area and physician engagement team.

**Task**
3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, asthma educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.

**Task**
4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP’s central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.

**Task**
5 Develop telemedicine capabilities within the ACP central back office Care Coordination/ Care management.

**Task**
6 Review “hot spotting” results and CNA resource analysis, ACP network analysis and REAL data to target patients meeting those criteria for telemedicine and in the language and culturally sensitive manner as appropriate.

**Task**
7 Perform analysis of accessibility of broadband services in areas where CNA analysis reveals the need to implement telemedicine to augment services and bridge gaps.

**Task**
8 PPS to leverage Community Engagement team to negotiate with broadband service providers in areas where this service is necessary for population wide reach of care for reduced rates and incentives.

**Milestone #3**
Deliver educational activities addressing asthma management to participating primary care providers.

**Task**
Participating providers receive training in evidence-based asthma management.

**Task**
1 Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO.
New York State Department Of Health  
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New York State Department Of Health
Delivery System Reform Incentive Payment Project
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Prescribed Milestones Current File Uploads

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Prescribed Milestones Narrative Text

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<tr>
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<tbody>
<tr>
<td>Implement evidence-based asthma management guidelines between primary care practitioners,</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale commitments made in the PPS’s submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>specialists, and community-based asthma programs (e.g., NYS Regional Asthma</td>
<td>permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been</td>
</tr>
<tr>
<td>Coalitions) to ensure a regional population based approach to asthma</td>
<td>ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction</td>
</tr>
<tr>
<td>management.</td>
<td>of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>Establish agreements to adhere to national guidelines for asthma management</td>
<td>In the interest of transparency, it should be noted that the speed and scale information in this Implementation Plan/Quarterly Report is identical to the speed and scale</td>
</tr>
<tr>
<td>and protocols for access to asthma specialists, including EHR-HIE connectivity</td>
<td>commitments made in the PPS's submission to the New York State Department of Health in January 2015. However, a significant group of physicians subsequently was</td>
</tr>
<tr>
<td>and telemedicine.</td>
<td>permitted to withdraw from the PPS, which has made it difficult to incorporate the January 2015 projections into this Implementation Plan. Discussions have been</td>
</tr>
<tr>
<td></td>
<td>ongoing with the New York State Department of Health regarding how to address the impact of the change in the PPS's provider roster on the ramp up and satisfaction</td>
</tr>
<tr>
<td>Delivered educational activities addressing asthma management to participating</td>
<td>of the Speed and Scale commitments.</td>
</tr>
<tr>
<td>primary care providers.</td>
<td></td>
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<tr>
<td>Ensure coordination with the Medicaid Managed Care organizations and</td>
<td></td>
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<td>Health Homes serving the affected population.</td>
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<tr>
<td>Use EHRs or other technical platforms to track all patients engaged in this</td>
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<tr>
<td>project.</td>
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</table>
**IPQR Module 3.d.iii.5 - PPS Defined Milestones**

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones.

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<th>Quarter End Date</th>
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**PPS Defined Milestones Narrative Text**

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</table>
IPQR Module 3.d.iii.6 - IA Monitoring

Instructions:
### Project 4.b.i – Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

- **IPQR Module 4.b.i.1 - PPS Defined Milestones**

**Instructions:**
Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones. For Domain 4 projects, these milestones must align with content submitted in the PPS Application.

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<tr>
<th>Milestone/Task Name</th>
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<tr>
<td>Data Analysis</td>
<td>In Progress</td>
<td>Analyze CNA results to understand prevalence of tobacco use in specific areas.</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task</strong></td>
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</tr>
<tr>
<td>1 Identification of Hotspots</td>
<td>In Progress</td>
<td>1 Analyze CNA data to determine “hotspots” (areas of highest incidence of tobacco use)</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td>2 Complete Analysis</td>
<td>In Progress</td>
<td>2 Complete analysis of CNA to identify resources within the “hot spot”</td>
<td>10/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>3 Community Health Workers</td>
<td>In Progress</td>
<td>3 Hire and train community health workers of the language and culture of the hot spot population served to provide outreach and promotion to populations underserved by most mass outlets and provide various degrees of engagement (large events, small group, etc).</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<td><strong>Milestone</strong></td>
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<tr>
<td>Develop and Implement Tobacco Use Cessation Protocol</td>
<td>In Progress</td>
<td>Develop tobacco use cessation protocol and deploy to providers within PPS.</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td><strong>Task</strong></td>
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<tr>
<td>1 Develop Evidence Based Protocols</td>
<td>Completed</td>
<td>1 Develop and implement evidence based protocols for assessing tobacco use and implementing tobacco use cessation therapies working in conjunction with physician leads and in accordance with NIH guidelines.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td>2 Disseminate Protocols with Providers</td>
<td>In Progress</td>
<td>2 Distribute protocols and procedures at physician engagement meetings, Care team meetings, electronically and utilizing provider engagement teams.</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<td><strong>Milestone</strong></td>
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<tr>
<td>Educational Campaign</td>
<td>In Progress</td>
<td>Develop and implement educational campaign and protocols for ACP providers</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td><strong>Task</strong></td>
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<tr>
<td>1 Protocol Implementation</td>
<td>In Progress</td>
<td>1 Utilize provider engagement team to provide on-site training and education at individual practices on implementing of protocols and procedures for assessing and treating tobacco use.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>2 Promote Use of EHR</td>
<td>In Progress</td>
<td>2 Promote amongst ACP’s partners a workflow that includes the use of tobacco use assessment tools specifically the 5 A’s incorporating the assessment tool into the EMR</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td><strong>Task</strong></td>
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<tr>
<td>3 Providers implement treatment plans in accordance with evidence based protocols</td>
<td>In Progress</td>
<td>3 Providers implement treatment plans in accordance with evidence based protocols</td>
<td>09/30/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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### DSRIP Implementation Plan Project

#### Advocate Community Providers, Inc. (PPS ID: 25)

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<tr>
<td>3 Implement Treatment Plan</td>
<td>In Progress</td>
<td>for tobacco use cessation intervention</td>
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<tr>
<td><strong>Milestone Engage MCOs Regarding Benefit Package</strong></td>
<td>In Progress</td>
<td>Initiate tobacco reimbursement and benefit negotiations with MCO.</td>
<td>10/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task 1 Data Analysis</strong></td>
<td>In Progress</td>
<td>1 Analyze tobacco use costs to healthcare, including costs associated with all secondary effects of tobacco, precipitation of disease, aggravation of disease.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task 2 Engage MCOs</strong></td>
<td>In Progress</td>
<td>2 Leverage relationships and partnerships between MCOs and physicians and physician groups to bring to the table high level administrators to negotiate coverage of evidence based treatments at no cost to the patient.</td>
<td>01/01/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task 3 Present Cost Analysis</strong></td>
<td>In Progress</td>
<td>3 Present cost analysis and ROI for early intervention and cost of tobacco cessation treatment including treatment that is pharmaceutical and / or cessation counseling. Utilize analysis results to determine initiatives from incentives to outreach support.</td>
<td>07/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task 4 Partnership Strategies</strong></td>
<td>In Progress</td>
<td>4 Use community health workers and community resources, pharmaceutical companies, MCOs and others to negotiate patient incentives for adherence to tobacco cessation programs and treatment plans and for successful attainment of goals.</td>
<td>07/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Milestone CBO Support and Resources</strong></td>
<td>In Progress</td>
<td>Seek out and establish a network of community-based support resources.</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task 1 Identify Key Providers and Support Agencies</strong></td>
<td>In Progress</td>
<td>1 Identify key contacts at and establish partnerships with local government and community based organizations that have established, proven track record in promoting tobacco use cessation. Such entities include NYQUITS, local community daycare and social centers, churches, schools. etc. to promote healthy lifestyle and tobacco free zones.</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task 2 Educational Materials</strong></td>
<td>In Progress</td>
<td>2 In conjunction with physician leads, tobacco cessation champions, clinical quality committees develop educational materials in several languages and culturally appropriate manner educating patients on tobacco use and its effects and detriment to health at primary and secondary exposure. Educational materials will be shared with key providers and other support agencies.</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Milestone Screening and Treatment Campaign</strong></td>
<td>In Progress</td>
<td>Implement population wide screening and treatment of patients with Media campaign with key partners, providers and other support agencies.</td>
<td>10/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task 1 Media Campaign</strong></td>
<td>In Progress</td>
<td>1 With communications team develop “Talk to your doctor about Tobacco” media campaign highlighting tobacco use effects, through primary and secondary exposure, Quit techniques and resources</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task 2 Educational Materials</strong></td>
<td>In Progress</td>
<td>2 In conjunction with tobacco cessation champion partners such as Jamaica Hospital; Develop educational materials on the effects and consequences of tobacco use.</td>
<td>10/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task 3 Disseminate Educational Materials</strong></td>
<td>In Progress</td>
<td>3 Disseminate educational materials via print, visual, audio and electronic media. Utilize community health workers and CBOs to disseminate materials within the communities.</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
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<tr>
<td>Task 4 Engage Media Outlets to Increase Effectiveness of Existing Campaigns</td>
<td>In Progress</td>
<td>4 Leverage established relationships with key providers and stakeholders. Partner with New York City organizations which are already providing tobacco use cessation through the media to increase outreach to communities that may not be attentive to them as of now.</td>
<td>04/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td>Task 5 Culturally Sensitive Educational Materials</td>
<td>In Progress</td>
<td>5 Ensure that all materials are made available and distributed in the communities in a language and culture that is appropriate and sensitive.</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td>Milestone Care Coordination Plans</td>
<td>In Progress</td>
<td>Develop Care Coordination Plans Using Evidence-Based Protocols As Part of the Integrated Delivery System</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Task 1 Evidence Based Protocols and Assessments</td>
<td>In Progress</td>
<td>1 In conjunction with physician leads and in accordance with NCBI and CDC guidelines, Develop Evidence based tobacco cessation protocols which include assessments incorporated into EMR, treatment plans both pharmaceutical treatments as well as cessation counseling.</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task 2 Disseminate Evidence Based Protocols</td>
<td>In Progress</td>
<td>2 Disseminate and Implement evidence based protocols for tobacco use cessation. Physician engagement teams shall deliver and train practices on the use of the protocols and process and procedures contained within.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 3 Care Coordination Processes</td>
<td>In Progress</td>
<td>3 As mandated within protocol, develop processes for care coordination processes for referral and follow up and follow through of services. Develop Back Office/Care Coordination, Care Management teams to receive and follow through in the integrated model of care with completion of referrals/services and link to community resources and social services to assist and provide care for patients as requested by providers.</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td>Task 4 Care Team Support</td>
<td>In Progress</td>
<td>4 Structure Care teams to support tobacco use cessation intervention and provide Care Coordinators with appropriate information through ACP's IT platform to support the IDS</td>
<td>01/01/2016</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task 5 Determine Success Factors</td>
<td>In Progress</td>
<td>5 Measure effectiveness of care coordination and support. Success of programs will need to incorporate culture of population. ACP will establish processes and educational materials to ensure cultural definitions and images of tobacco use are addressed and corrected. ACP will use whenever possible warm handoffs to specialty services and programs, will prioritize needs and provide ongoing monitoring via the Care Coordination teams and Community Health Workers.</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task 6 Connect to HIE with Provider Network</td>
<td>In Progress</td>
<td>6 Connect via EMR, RHIO, SHINY, ACP IT Platform; all network providers to provide efficient information exchange and expedite services. IT platform will include secure login for information exchange between PPS and community partners without EMRs.</td>
<td>01/01/2016</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Milestone Success Factors</td>
<td>In Progress</td>
<td>Include Key Success Factors Within Plan Including Analytics to Determine Effectiveness of Programs</td>
<td>07/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 1 Utilize EMR Data Capabilities Specific to Tobacco Use Cessation Initiative</td>
<td>In Progress</td>
<td>1 Leverage existing EMR meaningful use data mining capabilities to identify, gather information on and target all tobacco users to develop reporting metrics</td>
<td>07/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td>Task 2 Establish Reporting Metrics</td>
<td>In Progress</td>
<td>2 Develop algorithm and trending for evaluating success rates based on initial and follow up assessment tool responses. These include number of packs per day, number of cigarettes a day, how long after waking up in the morning, etc. Trending will show increases and decreases that can be used to evaluate care plan effectiveness.</td>
<td>07/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 3 Comparative Analytics and Application</td>
<td>In Progress</td>
<td>3 Develop comparison data analytics between data mined from assessment tool responses/by zones (hot spots)/amount of created and disseminated educational resources/ACP partner to establish more population wide effectiveness of programs.</td>
<td>10/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Milestone Partnerships with Other PPSs</td>
<td>In Progress</td>
<td>Partner with Other PPSs for Comprehensive Population Health Initiatives</td>
<td>07/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 1 PPS Partnerships</td>
<td>In Progress</td>
<td>1 Foster relationships with other PPS leads to discuss efforts being provided in tobacco use cessation.</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 2 Shared Campaigns and Initiatives</td>
<td>In Progress</td>
<td>2 Meet with and provide other PPS’ assistance and join resources for the creation and dissemination of population wide campaigns and initiatives.</td>
<td>04/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 3 Partnerships with City Agencies</td>
<td>In Progress</td>
<td>3 Leverage existing relationship with New York City Department of Health to meet with other PPS’ and establish collaborative efforts for city wide campaigns.</td>
<td>07/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<td>Educational Campaign</td>
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<tr>
<td>Engage MCOs Regarding Benefit Package</td>
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<td>CBO Support and Resources</td>
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<td>Screening and Treatment Campaign</td>
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<td>Care Coordination Plans</td>
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NYS Confidentiality – High
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Advocate Community Providers, Inc.  (PPS ID:25)

PPS Defined Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
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<tr>
<td>Success Factors</td>
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<tr>
<td>Partnerships with Other PPSs</td>
<td></td>
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</tbody>
</table>
IPQR Module 4.b.i.2 - IA Monitoring

Instructions:

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NYS Confidentiality – High
Project 4.b.ii – Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)

**IPQR Module 4.b.ii.1 - PPS Defined Milestones**

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones. For Domain 4 projects, these milestones must align with content submitted in the PPS Application.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNA Analysis</td>
<td>In Progress</td>
<td>ACP analyzed CNA data to understand prevalence of diseases in particular areas. It is developed to achieve primary goal of chronic disease prevention, early detection of chronic disease and early intervention. ACP has the following protocol targets: - Colon Cancer: Colorectal cancer screenings through fecal occult blood yearly, colonoscopy for both sexes at and after 50, every 5 years if negative, and yearly if positive findings are encountered - Breast Cancer: Promote and educate on periodic breast self-exams, provide Mammogram after age 40, every year - Prostate Cancer: Rectal prostate exam at and after age 50, yearly and/or PSA levels - Cervical Cancer: Pap Smears yearly - Lung Cancer: CT scan yearly for smokers - Hepatitis B and C: Safe Sex education and vaccination - HPV: Vaccination promotion for females ages 11 to 26 and males 11-21 - Promote other vaccinations in both children and adults as prescribed by CDC such as Pneumonia, Measles, etc. CNA data indicates an opportunity for optimal cancer management, preventative care and screening protocols. ACP will expand current programs and leverage strengths to respond to these challenges and to meet the project requirements. ACP created a funds model to provide PPS partners with funding to implement high-quality protocols to address gaps in screening and disease management. ACP will use the broad network of providers to provide more education and assist the patient to gain access to preventive services available within their community. This will include collaboration with community-based organizations (CBOs) to identify locations and resources to best meet the needs of patients. MCO discussions will be...</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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Advocate Community Providers, Inc. (PPS ID:25)

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<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task 1 Identify Hotspots</strong></td>
<td>In Progress</td>
<td>1 Complete analysis of CNA results to identify &quot;hot spots&quot; of high prevalence of diseases such as Cancer and Hepatitis.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task 2 Resources Within Hotspots</strong></td>
<td>In Progress</td>
<td>2 Complete analysis of CNA to identify resources within the &quot;hot spot&quot;</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Milestone Evidence Based Protocols</strong></td>
<td>In Progress</td>
<td>Create and implement evidence based protocols for prevention and screening for Chronic diseases.</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task 1 Develop Protocol</strong></td>
<td>Completed</td>
<td>1 In conjunction with physician leads and in accordance with national standards develop protocol for screening, educating and providing preventive care to target population.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
<tr>
<td><strong>Task 2 Protocol Criteria</strong></td>
<td>Completed</td>
<td>2 Protocols will stipulate criteria on how, when and on whom to perform screening exams as well as whom to provide with preventive care and education.</td>
<td>04/01/2015</td>
<td>06/30/2015</td>
<td>06/30/2015</td>
<td>DY1 Q1</td>
</tr>
</tbody>
</table>
| **Task 3 Achievement of Goals** | In Progress | 3 Care Teams and Clinical Quality Committees will review protocol and for compliance with specified ACP project goals in accordance with American Cancer Society and CDC Recommendations:  
- Colon Cancer: Colorectal cancer screenings through fecal occult blood yearly, colonoscopy for both sexes at and after age 50, every 10 years if negative  
- Breast Cancer: Promote and educate patient on periodic Breast self exams, and provide Mammogram after age 40, every year and every 2-3 years for women in their 20's and 30's  
- Prostate Cancer: Starting at age 50, providers should talk to the patient about the pros and cons of testing so they can decide if testing is the right choice for them. For African American men or those who have a father or brother who had prostate cancer before age 65, this talk should start at age 45. If patient agrees to testing, then PSA test and/or Rectal prostate exam shall be performed.  
- Cervical Cancer: Pap Smears every 3 years  
- Lung Cancer: CT scan for those who are at high risk of lung cancer due to cigarette smoking. If all of the following: 55 to 74 years of age, In fairly good health, has at least a 30 pack-year smoking history AND is either still smoking or has quit smoking within the last 15 years  
- Hepatitis B and C: Safe Sex education and Hep B vaccination  
- HPV: Vaccination promotion for females ages 11 to 26 and males 11-21  
- Promote other vaccinations in both children and adults as prescribed by CDC such as Pneumonia, Measles, etc. | 07/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |
| **Milestone Target Population** | In Progress | Understand Target Population for Engagement | 10/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3 |
| **Task** | In Progress | 1 Drill down CNA results to identify patterns and trends amongst populations. CNA | 10/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 |

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## Advocate Community Providers, Inc. (PPS ID: 25)

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<tr>
<td><strong>Milestone</strong></td>
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<td><strong>Leverage Existing Resources</strong> to Promote Preventive Health</td>
<td>10/01/2015</td>
<td>09/30/2017</td>
<td>09/30/2017</td>
<td>DY3 Q2</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td><strong>1 Engage Medical Societies and Other Community Stakeholders</strong></td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>2 Care Coordinator and CHW Patient Outreach</strong></td>
<td>In Progress</td>
<td>2 Establish relationships and work with American Cancer Society, NYC DOH, American Academy of Pediatrics, Community Stakeholders, and Pharmacology Companies on enhancing care and providing population wide educational campaigns on chronic disease prevention.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Task</strong></td>
<td></td>
<td><strong>3 Engage With CBOs</strong></td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>4 CBO Education and Outreach</strong></td>
<td>In Progress</td>
<td>2 Utilize Community Health Workers from the communities identified that understand the language and culture. CHWs will be used by ACP to outreach to the population for general outreach and promotion of preventive care.</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td><strong>Task</strong></td>
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<td><strong>5 Registries to Target Non-Compliant Population</strong></td>
<td>01/01/2016</td>
<td>12/31/2016</td>
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<td><strong>Task</strong></td>
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<td><strong>3 Community Based Organizations</strong></td>
<td>10/01/2015</td>
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<tr>
<td><strong>Task</strong></td>
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<td><strong>2 Employ Community Health Workers (CHW)</strong></td>
<td>01/01/2016</td>
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<td><strong>Task</strong></td>
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<td><strong>5 MCO Engagement for Incentive Models</strong></td>
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<td><strong>Task</strong></td>
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<td><strong>4 CBO Agreements</strong></td>
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<td><strong>Task</strong></td>
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<td><strong>1 CNA Population Trends</strong></td>
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<td>12/31/2016</td>
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**New York State Department Of Health**

**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**
## Advocate Community Providers, Inc. (PPS ID:25)

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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td><strong>Task</strong> 1 Clinical Decision Support System (CDSS) and Patient Registries to Identify and Target Patients</td>
<td>In Progress</td>
<td>1 Utilize EMRs to establish CDSS alerts, run registry reports to send reminders, to provide providers with the tools that they need to engage patients effectively and timely.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Milestone</strong> Use of EHRs for Clinical Decision Support</td>
<td>In Progress</td>
<td>Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality.</td>
<td>10/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 2 Establish Workflow Steps on Patient Engagement</td>
<td>In Progress</td>
<td>2 Set periodicity for sending recalls and reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Milestone</strong> Medical Home or Team Based Care Models</td>
<td>In Progress</td>
<td>Adopt medical home or team-based care models.</td>
<td>10/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 1 Care Team Based Model</td>
<td>In Progress</td>
<td>1 Create a care team based model to ensure whole-person preventive care to patient. Care teams are regional providers who will clinically integrate to deliver care. The PPS will provide administrative support such as care coordination and care management to ensure care teams, physicians and patients are engaged.</td>
<td>10/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 2 Deploy Care Team Based Model</td>
<td>In Progress</td>
<td>2 Build on care team structure, and work through community and provider engagement teams to strengthen and expand our existing network of medical homes.</td>
<td>10/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Milestone</strong> Clinical Benchmarks</td>
<td>In Progress</td>
<td>Establish and provide feedback to clinicians around clinical benchmarks.</td>
<td>01/01/2016</td>
<td>12/31/2017</td>
<td>12/31/2017</td>
<td>DY3 Q3</td>
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<tr>
<td><strong>Task</strong> 1 Align Incentives</td>
<td>In Progress</td>
<td>1 Align incentives with delivery of preventive care as well as outcomes.</td>
<td>01/01/2016</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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<tr>
<td><strong>Task</strong> 2 Establish Performance Metrics</td>
<td>In Progress</td>
<td>2 Establish performance metrics to be used for monitoring adherence to protocols and procedures as well as performance. Metric shall include CPT codes obtained from claims data sources such as salient, MCOs denoting procedures performed and billed for comparison data analytics, and data pulls from EMR patient registry data and PCMH and MU level data regarding resulted screenings and vaccinations.</td>
<td>01/01/2016</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
</tr>
<tr>
<td><strong>Task</strong> 3 Establish Monthly Meetings to Understand Performance</td>
<td>In Progress</td>
<td>3 As per ACP governance structure, establish monthly monitoring on all performance measures for project-specific goals. Create reports to distribute to providers to tie performance to desired outcomes.</td>
<td>03/01/2016</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
</tr>
<tr>
<td><strong>Milestone</strong> Address Out of Pocket Costs for Patients for Preventive Services</td>
<td>In Progress</td>
<td>Reduce or eliminate out-of-pocket costs for clinical and community preventive services. The PPS is already working with MCOs in enhancing coverage for preventive services</td>
<td>01/01/2016</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>1 PPS will negotiate with partner MCOs in enhancing coverage for preventive</td>
<td>01/01/2016</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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NYS Confidentiality – High
# New York State Department Of Health
## Delivery System Reform Incentive Payment Project
### DSRIP Implementation Plan Project

**Advocate Community Providers, Inc. (PPS ID:25)**

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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>1 Engage with MCOs</td>
<td></td>
<td>services. Leverage existing relationships with MCOs to open discussions regarding broadening the scope of services covered to include additional preventive care services such as vaccines at no cost to patient.</td>
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<tr>
<td>Task 2 Engage with Pharmaceuticals</td>
<td>In Progress</td>
<td>2 PPS to negotiate with pharmaceutical companies to provide incentives to patients for compliance, for example providing cost reduction, copay and/or coinsurance assistance for vaccinations.</td>
<td>01/01/2016</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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<tr>
<td>Milestone Care Coordination Plans</td>
<td>In Progress</td>
<td>Develop Care Coordination Plans Using Evidence-Based Protocols As Part of the Integrated Delivery System</td>
<td>10/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task 1 Establish Centralized Care Management System</td>
<td>In Progress</td>
<td>1 Establish a centralized Care Management system that will have Care Managers, Care Coordinators, Educators and Social Workers and incorporate many aspects of the Medical Home/Team-Based Models.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task 2 Use Centralized CM System for Care Coordination</td>
<td>In Progress</td>
<td>2 Utilize the centralized Care management system to coordinate care across the expansive integrated network of specialty, social services providers, and community stakeholders to ensure all stakeholders participate in the care and compliance of the patients. ACP will also leverage MediSys experienced network of PCMH clinics and expand that model to other areas of the PPS.</td>
<td>10/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task 3 Centralized System IT</td>
<td>In Progress</td>
<td>3 Integrate Care management as part of IT solution which includes centralized functions, workflows that incorporate the protocols and effective communication channels between partners.</td>
<td>01/01/2016</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Task 4 System Training</td>
<td>In Progress</td>
<td>4 Provide proper training and education to the workforce to ensure processes are followed and included within partner organizations’ workflows.</td>
<td>07/01/2016</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>Milestone Partnerships with Other PPSs</td>
<td>In Progress</td>
<td>Partner with Other PPSs for Comprehensive Population Health Initiatives</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 1 Establish PPS Partnerships</td>
<td>In Progress</td>
<td>1 Identify key personnel in surrounding PPS’ and set up negotiations and collaboration/partnerships structure with all PPS’ in ACP’s geographical area.</td>
<td>01/01/2016</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td>Task 2 Develop Shared Initiatives</td>
<td>In Progress</td>
<td>2 Develop and deploy shared initiatives for each PPS that focus on preventive services.</td>
<td>04/01/2016</td>
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### PPS Defined Milestones Current File Uploads

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## PPS Defined Milestones Narrative Text

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<tbody>
<tr>
<td>CNA Analysis</td>
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<tr>
<td>Evidence Based Protocols</td>
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<td>Target Population</td>
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<tr>
<td>Leverage Existing Resources</td>
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<tr>
<td>Establish Formal Preventive Care Model</td>
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<td>Use of EHRs for Clinical Decision Support</td>
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<td>Medical Home or Team Based Care Models</td>
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<td>Clinical Benchmarks</td>
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<tr>
<td>Address Out of Pocket Costs for Patients for Preventive Services</td>
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<td>Care Coordination Plans</td>
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</tr>
<tr>
<td>Partnerships with Other PPSs</td>
<td></td>
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</tbody>
</table>
IPQR Module 4.b.ii.2 - IA Monitoring

Instructions:

Milestone 2: The IA recommends assuring that screening protocols are evidence based, (e.g., Women between ages 21 and 29 should have a Pap test done every 3 years. HPV testing should not be used in this age group unless it's needed after an abnormal Pap test result.)

Assure that screening agrees with evidence based protocols, amend as needed.


http://www.asge.org/assets/0/71542/71544/e49cb8b8-9e3d-4678-9252-0a415efd6c2d.pdf


Attestation

The Lead Representative has been designated by the Primary Lead PPS Provider (PPS Lead Entity) as the signing officiate for the DSRIP Quarterly Report. The Lead Representative has the authority to complete this attestation on behalf of the PPS network. The Lead Representative and PPS Lead Entity are responsible for the authenticity and accuracy of the material submitted in this report.

The Lead Representative of the Performing Provider System (PPS) must complete this attestation form in order for the project application to be accepted by the NYS Department of Health. Once the attestation is complete, the Quarterly Report will be locked down from any further editing. Do not complete this section until the entire Quarterly Report is complete.

If the Quarterly Report becomes locked in error and additional changes are necessary, please use the contact information on the Home Page to request that the Quarterly Report be unlocked.

To electronically sign this Quarterly Report, please enter the required information and check the box below:

I here by attest, as the Lead Representative of the ’Advocate Community Providers, Inc. ’, that all information provided on this Quarterly report is true and accurate to the best of my knowledge.

Primary Lead PPS Provider: TALLAJ RAMON MODESTO MD
Secondary Lead PPS Provider: 
Lead Representative: Josephine Wu
Submission Date: 09/25/2015 04:19 PM

Comments:
## Status Log

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<td>rt374083</td>
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Advocate Community Providers, Inc. (PPS ID:25)

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## DSRIP Implementation Plan Project

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