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

DSRIP Implementation Plan Project

NewYork-Presbyterian/Queens (PPS ID:40)

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Quarterly Report - Implementation Plan for NewYork-Presbyterian/Queens

Year and Quarter: DY1, Q3 **Quarterly Report Status:** Adjudicated

Status By Section

Section	Description	Status
Section 01	Budget	Completed
Section 02	Governance	Completed
Section 03	Financial Stability	Completed
Section 04	Cultural Competency & Health Literacy	Completed
Section 05	IT Systems and Processes	Completed
Section 06	Performance Reporting	Completed
Section 07	Practitioner Engagement	Completed
Section 08	Population Health Management	Completed
Section 09	Clinical Integration	Completed
Section 10	General Project Reporting	Completed
Section 11	Workforce	Completed

Status By Project

Project ID	Project Title	Status
2.a.ii	Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))	Completed
2.b.v	Care transitions intervention for skilled nursing facility (SNF) residents	Completed
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	Completed
2.b.viii	Hospital-Home Care Collaboration Solutions	Completed
3.a.i	Integration of primary care and behavioral health services	Completed
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	Completed
3.d.ii	Expansion of asthma home-based self-management program	Completed
3.g.ii	Integration of palliative care into nursing homes	Completed
4.c.ii	Increase early access to, and retention in, HIV care	Completed

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget Report (Baseline)

Instructions :

This table contains five budget categories. Please add rows to this table as necessary in order to add your own 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 the box provided.

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	1,837,562	1,958,237	3,166,715	2,804,114	1,837,562	11,604,191
Cost of Project Implementation & Administration	**14,356,985**	**2,414,117**	**3,899,727**	**3,456,900**	**2,256,985**	**26,384,714**
Cost of Implementation	13,454,191	1,448,470	2,339,836	2,074,140	1,354,191	20,670,828
Administration	902,794	965,647	1,559,891	1,382,760	902,794	5,713,886
Revenue Loss	**451,397**	**482,823**	**779,945**	**691,380**	**451,397**	**2,856,942**
Internal PPS Provider Bonus Payments	**1,263,911**	**1,351,905**	**2,183,847**	**1,935,864**	**1,263,911**	**7,999,438**
Cost of non-covered services	**225,698**	**241,412**	**389,973**	**345,690**	**225,698**	**1,428,471**
Other	**315,977**	**337,977**	**545,962**	**483,966**	**315,977**	**1,999,859**
Contingency	225,698	241,412	389,973	345,690	225,698	1,428,471
Workforce	90,279	96,565	155,989	138,276	90,279	571,388
Total Expenditures	**16,613,968**	**4,828,234**	**7,799,454**	**6,913,800**	**4,513,968**	**40,669,424**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

The PPS was awarded Safety Net Equity funds which were included in the budget building and forecasting process. Therefore, the information entered in the budget table exceeds the pre-built totals per DY.

Additionally, the Other bucket in the table is inclusive of the contingency funds and the workforce training funds.

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Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 1.2 - PPS Budget Report (Quarterly)

Instructions :

Please include updates on budget items for this quarterly reporting period. Reported actual spending will be compared to baseline projections and deviations will be evaluated.
Any explanations regarding deviations from baseline projections must be included within the textbox, not as narrative within uploaded documentation.

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
1,837,562	11,604,191	1,238,552	11,005,181

Budget Items	DY1 Q3 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**390,565**	**598,510**	**13,758,475**	**95.83%**	**25,786,204**	**97.73%**
Cost of Implementation	99,750					
Administration	290,815					
Revenue Loss	**0**	**0**	**451,397**	**100.00%**	**2,856,942**	**100.00%**
Internal PPS Provider Bonus Payments	**0**	**0**	**1,263,911**	**100.00%**	**7,999,438**	**100.00%**
Cost of non-covered services	**0**	**0**	**225,698**	**100.00%**	**1,428,471**	**100.00%**
Other	**500**	**500**	**315,477**	**99.84%**	**1,999,359**	**99.97%**
Contingency	0					
Workforce	500					
Total Expenditures	**391,065**	**599,010**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.3 - PPS Flow of Funds (Baseline)

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)

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	1,837,562	1,958,237	3,166,715	2,804,114	1,837,562	11,604,191
Practitioner - Primary Care Provider (PCP)	203,352	217,510	351,362	311,464	203,352	1,287,040
Practitioner - Non-Primary Care Provider (PCP)	123,382	131,972	213,186	188,978	123,382	780,900
Hospital	203,352	217,510	351,362	311,464	203,352	1,287,040
Clinic	128,454	137,397	221,948	196,745	128,454	812,998
Case Management / Health Home	108,391	115,938	187,284	166,017	108,391	686,021
Mental Health	175,261	187,462	302,824	268,437	175,261	1,109,245
Substance Abuse	33,158	35,467	57,292	50,787	33,158	209,862
Nursing Home	110,899	118,620	191,617	169,858	110,899	701,893
Pharmacy	81,307	86,968	140,487	124,534	81,307	514,603
Hospice	35,109	37,553	60,663	53,774	35,109	222,208
Community Based Organizations	61,245	65,509	105,823	93,806	61,245	387,628
All Other	0	0	0	0	0	0
PPS PMO	1,056,825	1,492,419	1,118,786	1,118,786	1,118,786	5,905,602
Total Funds Distributed	**2,320,735**	**2,844,325**	**3,302,634**	**3,054,650**	**2,382,696**	**13,905,040**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

New York State Department Of Health
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Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 1.4 - PPS Flow of Funds (Quarterly)

Instructions :

Please include updates on flow of funds for this quarterly reporting period. Reported actual fund distribution will be compared to baseline projections and deviations will be evaluated.
Any explanations regarding deviations from baseline projections must be included within the textbox, not as narrative within uploaded documentation.

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
1,837,562	11,604,191	1,837,562	11,604,191

Funds Flow Items	DY1 Q3 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project										DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS											
			2.a.ii	2.b.v	2.b.vii	2.b.viii	3.a.i	3.b.i	3.d.ii	3.g.ii	4.c.ii			
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0		203,352	1,287,040
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0		123,382	780,900
Hospital	0	0	0	0	0	0	0	0	0	0	0		203,352	1,287,040
Clinic	0	0	0	0	0	0	0	0	0	0	0		128,454	812,998
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0		108,391	686,021
Mental Health	0	0	0	0	0	0	0	0	0	0	0		175,261	1,109,245
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0		33,158	209,862
Nursing Home	0	0	0	0	0	0	0	0	0	0	0		110,899	701,893
Pharmacy	0	0	0	0	0	0	0	0	0	0	0		81,307	514,603
Hospice	0	0	0	0	0	0	0	0	0	0	0		35,109	222,208
Community Based Organizations	0	0	0	0	0	0	0	0	0	0	0		61,245	387,628
All Other	0	0	0	0	0	0	0	0	0	0	0		0	0
PPS PMO	0	0	0	0	0	0	0	0	0	0	0		1,056,825	5,905,602
Total Funds Distributed	**0**	**0**												

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.5 - Prescribed Milestones

Instructions :

Please provide updates to baseline target dates and work breakdown tasks with target dates for required 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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Completed	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.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1... PMO to create project-specific provider roles, budgets, and funds flow distribution models	Completed	Step 1... PMO to create project-specific provider roles, budgets, and funds flow distribution models	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2... PMO finance staff to create a partner level funds flow risk model	Completed	Step 2... PMO finance staff to create a partner level funds flow risk model	09/01/2015	11/01/2015	09/01/2015	11/01/2015	12/31/2015	DY1 Q3	
Task Step 3... PMO finance staff to create a multi-year anticipated funds distribution plan based on anticipated AV values	Completed	Step 3... PMO finance staff to create a multi-year anticipated funds distribution plan based on anticipated AV values	08/01/2015	10/01/2015	08/01/2015	10/01/2015	12/31/2015	DY1 Q3	
Task Step 4... PMO Executive to present budget, funds flow models, risk model, and multi-year anticipated distribution plan to the Finance Committee for review and approval	Completed	Step 4... PMO Executive to present budget, funds flow models, risk model, and multi-year anticipated distribution plan to the Finance Committee for review and approval	10/01/2015	11/15/2015	10/01/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Step 5... Finance Committee to present to Executive Committee for approval	Completed	Step 5... Finance Committee to present to Executive Committee for approval	11/15/2015	12/31/2015	11/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6... Executive Committee, project committees, and the PMO provider agreement process will all inform the communication of financial funds flow plan to PPS partners.	Completed	Step 6... Executive Committee, project committees, and the PMO provider agreement process will all inform the communication of financial funds flow plan to PPS partners.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 7…Legal team to incorporate funds flow plan into PPS participating agreements & addendums	Completed	Step 7…Legal team to incorporate funds flow plan into PPS participating agreements & addendums	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 8…PMO Executive to communicate funds flow plan to PPS partners & clinical sub committees	Completed	Step 8…PMO Executive to communicate funds flow plan to PPS partners & clinical sub committees	12/01/2015	12/31/2015	12/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Complete funds flow budget and distribution plan and communicate with network	sak2047	Documentation/Certification	40_MDL0103_1_3_20160315093634_Finance_Milestone_1_Packet_03_15_16.pdf	Finance Milestone 1 DY1, Q3 Remediation Documentation	03/15/2016 09:36 AM
	cc599179	Meeting Materials	40_MDL0103_1_3_20160129122518_NYPQ_PPS_Finance_Committee_Meeting_12_17_15_for_MAPP_Q3_Report.pptx	Funds Flow & Budget	01/29/2016 12:25 PM
	cc599179	Templates	40_MDL0103_1_3_20160129122357_Meeting_Schedule_-_Finance_Committee_012916.xlsx	Meeting Schedule - Finance	01/29/2016 12:23 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Complete funds flow budget and distribution plan and communicate with network	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Complete	

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IPQR Module 1.6 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.7 - IA Monitoring

Instructions :

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	07/30/2015	04/01/2015	07/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1…Obtain approval from Lead Hospital (NYHQ) Board of Trustees for Executive Committee	Completed	Step 1…Obtain approval from Lead Hospital (NYHQ) Board of Trustees for Executive Committee	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2…Create governing structure to include committees & sub-committees	Completed	Step 2…Create governing structure to include committees & sub-committees	04/01/2015	05/01/2015	04/01/2015	05/01/2015	06/30/2015	DY1 Q1	
Task Step 3…Solicit volunteers from partners for all committees & sub-committees for presentation to the Exec Committee	Completed	Step 3…Solicit volunteers from partners for all committees & sub-committees for presentation to the Exec Committee	05/01/2015	06/01/2015	05/01/2015	06/01/2015	06/30/2015	DY1 Q1	
Task Step 4…Draft charters with input from the legal team and DSRIP executives	Completed	Step 4…Draft charters with input from the legal team and DSRIP executives	04/01/2015	05/01/2015	04/01/2015	05/01/2015	06/30/2015	DY1 Q1	
Task Step 5...Hold first meeting of Executive Committee: a. Adopt Executive Committee charter & ratify membership b. Approve committee charters and committee chairs/co-chairs	Completed	Step 5...Hold first meeting of Executive Committee: a. Adopt Executive Committee charter & ratify membership b. Approve committee charters and committee chairs/co-chairs	06/01/2015	07/01/2015	06/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task	Completed	Step 6…Distribute & present governing structure to	06/01/2015	07/15/2015	06/01/2015	07/15/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 6…Distribute & present governing structure to committees, sub-committees, and PAC		committees, sub-committees, and PAC							
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1…PMO & Committee Chair/Vice-Chair to review charters for Clinical Integration & Quality Committee	Completed	Step 1…PMO & Committee Chair/Vice-Chair to review charters for Clinical Integration & Quality Committee	07/01/2015	10/01/2015	07/01/2015	10/01/2015	12/31/2015	DY1 Q3	
Task Step 2… PMO & Committee chair/vice-chair to finalize membership of clinical Integration & Quality committee	Completed	Step 2… PMO & Committee chair/vice-chair to finalize membership of clinical Integration & Quality committee	07/01/2015	10/01/2015	07/01/2015	10/01/2015	12/31/2015	DY1 Q3	
Task Step 3…Host initial Clinical Integration and Quality Committee meeting & communicate expectations	Completed	Step 3…Host initial Clinical Integration and Quality Committee meeting & communicate expectations	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4…PMO to establish clinical sub-committees with membership listing & complete the initial kick-off meeting to align committee with expectations & provide DSRIP education	Completed	Step 4…PMO to establish clinical sub-committees with membership listing & complete the initial kick-off meeting to align committee with expectations & provide DSRIP education	04/01/2015	09/01/2015	04/01/2015	09/01/2015	09/30/2015	DY1 Q2	
Task Step 5… Clinical sub-committee chairs, and the IT/Performance Reporting Committee leads to make recommendations on metrics for tracking performance of the clinical sub committees	Completed	Step 5… Clinical sub-committee chairs, and the IT/Performance Reporting Committee leads to make recommendations on metrics for tracking performance of the clinical sub committees	07/01/2015	10/01/2015	07/01/2015	10/01/2015	12/31/2015	DY1 Q3	
Task Step 6…Clinical sub committees to review, revise, and adopt quality metrics for monthly/quarterly reporting specific to project in alignment with DSRIP Domains 2-4 metrics	Completed	Step 6…Clinical sub committees to review, revise, and adopt quality metrics for monthly/quarterly reporting specific to project in alignment with DSRIP Domains 2-4 metrics	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3	
Task Step 7…Clinical sub committee chair to communicate quality expectations to partners	Completed	Step 7…Clinical sub committee chair to communicate quality expectations to partners and the Executive Committee	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
and the Executive Committee									
Task Step 8…PMO to communicate clinical governance structure to PAC	Completed	Step 6…PMO to communicate clinical governance structure to PAC	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1...Establish the PPS operating agreement appropriate for Collaborative Contracting Mode	Completed	Step 1...Establish the PPS operating agreement appropriate for Collaborative Contracting Mode	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2...List number of policies that require Executive Committee approval and schedule for submission at Executive Committee monthly meetings. a. Policies may include but are not limited to: provider performance improvement, code of conduct, funds flow distribution, committee charters	Completed	Step 2...List number of policies that require Executive Committee approval and schedule for submission at Executive Committee monthly meetings. a. Policies may include but are not limited to: provider performance improvement, code of conduct, funds flow distribution, committee charters	06/01/2015	08/15/2015	06/01/2015	08/15/2015	09/30/2015	DY1 Q2	
Task Step 3…PMO to create system to track all documents that require Executive Committee approval via a project management software tool	Completed	Step 3…PMO to create system to track all documents that require Executive Committee approval via a project management software tool	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4…Communicate bylaw & policies to PAC	Completed	Step 4…Communicate bylaw & policies to PAC	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5… Executive Committee to approve and adopt agreements, bylaws and policies	Completed	Step 5… Executive Committee to approve and adopt agreements, bylaws and policies	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	Completed	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	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1...Establish in each committee charter the reporting and monitoring process that will be conducted by each committee including two-way	Completed	Step 1...Establish in each committee charter the reporting and monitoring process that will be conducted by each committee including two-way communication and developing initial metrics for tracking performance	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
communication and developing initial metrics for tracking performance									
Task Step 2… PMO & IT/Performance Reporting Committee to establish the types of reports and dashboards that will be provided to each committee to conduct its oversight responsibilities	Completed	Step 2… PMO & IT/Performance Reporting Committee to establish the types of reports and dashboards that will be provided to each committee to conduct its oversight responsibilities	09/01/2015	11/30/2015	09/01/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Step 3...Establish schedule of Executive Committee meetings for the year, minutes and official document processes and storage	Completed	Step 3...Establish schedule of Executive Committee meetings for the year, minutes and official document processes and storage	06/01/2015	07/01/2015	06/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task Step 4…PMO to utilize project management tool, Performance Logic, to ensure monthly reporting and progress updates from committees by partner/committee entry and establishment of monthly/quarterly dashboards	Completed	Step 4…PMO to utilize project management tool, Performance Logic, to ensure monthly reporting and progress updates from committees by partner/committee entry and establishment of monthly/quarterly dashboards	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5…Executive Committee to approve final dashboard	Completed	Step 5…Executive Committee to approve final dashboard	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	In Progress	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…PMO to review community stakeholder list and determine needed additions/deletions given work required to accomplish project goals	Completed	Step 1…PMO to review community stakeholder list and determine needed additions/deletions given work required to accomplish project goals	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2… PMO and Communications Committee to determine current community engagement programs to be leveraged, such as PPS partners in school clinics or the hospital Community Action Council, and identify gaps to be	Completed	Step 2… PMO and Communications Committee to determine current community engagement programs to be leveraged, such as PPS partners in school clinics or the hospital Community Action Council, and identify gaps to be addressed in the community engagement plan	06/01/2015	09/01/2015	06/01/2015	09/01/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
addressed in the community engagement plan									
Task Step 3… Communications Committee to write community engagement plan describing purpose, messages, frequency of communication exchange, types of organizations to be engaged	Completed	Step 3… Communications Committee to write community engagement plan describing purpose, messages, frequency of communication exchange, types of organizations to be engaged	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4...Identify and schedule community engagement events including use of website, newsletter, quarterly meetings, and annual community forums	Completed	Step 4...Identify and schedule community engagement events including use of website, newsletter, quarterly meetings, and annual community forums	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5…Community Engagement plan submitted to Communications Committee and Executive Committee for review and approval	In Progress	Step 5…Community Engagement plan submitted to Communications Committee and Executive Committee for review and approval	10/01/2015	01/31/2016	10/01/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Step 6…Community engagement plan presented to PAC	Not Started	Step 6…Community engagement plan presented to PAC	11/01/2015	02/29/2016	01/01/2016	02/29/2016	03/31/2016	DY1 Q4	
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	07/01/2015	12/31/2015	10/01/2015	06/15/2016	06/30/2016	DY2 Q1	NO
Task Step 1... PPS to draft PPS partner agreements, inclusive of project expectations and deliverables	Completed	Step 1... PPS to draft PPS partner agreements	07/01/2015	11/15/2015	10/01/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Step 2... PPS to execute PPS partner agreements	Completed	Step 2... PPS to execute PPS partner agreements	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3...PMO to identify list of CBO's for contracting specific to NYHQ project needs	Completed	Step 3...PMO to identify list of CBO's for contracting specific to NYHQ project needs	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4…PMO to identify role and expectations of CBO's to be included in the partnership agreements and write agreements specific to project engagement & expectations	Completed	Step 4…PMO to identify role and expectations of CBO's to be included in the partnership agreements and write agreements specific to project engagement & expectations	07/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6…PMO to engage CBOs in contracting	Completed	Step 6…PMO to engage CBOs in contracting process	07/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
process through face to face and electronic communication		through face to face and electronic communication							
Task Step 8..PMO to Identify and schedule community engagement events that CBO's will participate in	Completed	Step 8..PMO to Identify and schedule community engagement events that CBO's will participate in	09/01/2015	10/31/2015	10/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task Step 5…Present CBO list & draft CBO contracts to Executive Committee for approval	Completed	Step 5…Present CBO list & draft CBO contracts to Executive Committee for approval	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7…PMO to complete and execute CBO agreements	In Progress	Step 7…PMO to complete and execute CBO agreements	11/01/2015	12/31/2015	10/01/2015	06/15/2016	06/30/2016	DY2 Q1	
Task Step 9…Present CBO listing & agreement summary to PAC	Completed	Step 9…Present CBO listing & agreement summary to PAC	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #7 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.)	In Progress	Agency Coordination Plan.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1…PMO and Communications Committee to identify list of state and local public sector agencies to be engaged in each project	In Progress	Step 1…PMO and Communications Committee to identify list of state and local public sector agencies to be engaged in each project	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2… Communications Committee to develop Public Agency Coordination Plan specific to the need of NYHQ projects	Not Started	Step 2… Communications Committee to develop Public Agency Coordination Plan specific to the need of NYHQ projects	01/01/2016	05/31/2016	01/01/2016	05/31/2016	06/30/2016	DY2 Q1	
Task Step 3...Identify frequency of planning meetings with Agencies	Not Started	Step 3...Identify frequency of planning meetings with Agencies	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4…Community Engagement plan submitted to Communications committee and Executive Committee for review and approval	Not Started	Step 4…Community Engagement plan submitted to Communications committee and Executive Committee for review and approval	05/01/2016	08/01/2016	05/01/2016	08/01/2016	09/30/2016	DY2 Q2	
Task	Not Started	Step 5… Integrate agencies into committees & sub-committee	04/01/2016	09/01/2016	04/01/2016	09/01/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 5… Integrate agencies into committees & sub-committee as appropriate based on project needs		as appropriate based on project needs							
Milestone #8 Finalize workforce communication and engagement plan	In Progress	Workforce communication & 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).	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1…PMO Identify workforce groups that need communication and engagement	Completed	Step 1…PMO Identify workforce groups that need communication and engagement	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2 Identify common themes & best methods for communication to all workforce groups and to specific groups working directly with unions by gathering data	In Progress	Step 2 Identify common themes & best methods for communication to all workforce groups and to specific groups working directly with unions by gathering data	08/01/2015	12/31/2015	08/01/2015	02/15/2016	03/31/2016	DY1 Q4	
Task Step 3…PMO Executive and Workforce Committee Chair to meet with 1199TEF to identify partnership opportunities and union limitations for project implementation	Completed	Step 3…PMO Executive and Workforce Committee Chair to meet with 1199TEF to identify partnership opportunities and union limitations for project implementation	08/01/2015	11/30/2015	08/01/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Step 4…Workforce & Communications Committees to write workforce communication plan and obtain approval from Workforce, Communication Committees	Not Started	Step 4…Workforce & Communications Committees to write workforce communication plan and obtain approval from Workforce, Communication Committees	10/01/2015	03/31/2016	02/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Step 5…Plan for Employee Engagement Town Hall Meetings quarterly & publish schedule	Completed	Step 5…Plan for Employee Engagement Town Hall Meetings quarterly & publish schedule	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6…Establish a Workforce Dashboard Reporting Tool to be used to communicate deliverables of the committee as well as risks, planned mitigations, forecasting, etc.	Completed	Step 6…Establish a Workforce Dashboard Reporting Tool to be used to communicate deliverables of the committee as well as risks, planned mitigations, forecasting, etc.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7…Present to Workforce Communication & Engagement plan to the Executive Committee for	In Progress	Step 7…Present to Workforce Communication & Engagement plan to the Executive Committee for approval	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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approval									
Milestone #9 Inclusion of CBOs in PPS Implementation.	Completed	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.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task NYHQ PPS plans to maximize the engagement of our Community Based Organizations by ensuring strong collaboration, communication, and coordination among all patterns, practitioners, and organizations with specific insight into the expectations of all projects and or functions. CBO's will include organizations that will benefit our projects and patients such as; the Asthma Coalition of Queens, Catholic Charities, Self-help Community Services, Silvercrest Housing, and many more. There are currently 22 CBO partners which reflect 12 unique organizations that serve our population. The Community Based Organizations will be critical members of our PAC as well as appropriate governing committees, including project sub-committees, communications/stakeholder engagement, and workforce, outlined through our collaborative model and will be contracted based on an individual project, patient, and CBO need to ensure alignment with each DRSRIP deliverable expectation. Examples of CBO's include the Asthma Coalition, the NYCHA and others that have an impact on the clinical projects. The CBO contracting will be managed through the Executive Committee with recommendations	Completed	NYHQ PPS plans to maximize the engagement of our Community Based Organizations by ensuring strong collaboration, communication, and coordination among all patterns, practitioners, and organizations with specific insight into the expectations of all projects and or functions. CBO's will include organizations that will benefit our projects and patients such as; the Asthma Coalition of Queens, Catholic Charities, Self-help Community Services, Silvercrest Housing, and many more. There are currently 22 CBO partners which reflect 12 unique organizations that serve our population. The Community Based Organizations will be critical members of our PAC as well as appropriate governing committees, including project sub-committees, communications/stakeholder engagement, and workforce, outlined through our collaborative model and will be contracted based on an individual project, patient, and CBO need to ensure alignment with each DRSRIP deliverable expectation. Examples of CBO's include the Asthma Coalition, the NYCHA and others that have an impact on the clinical projects. The CBO contracting will be managed through the Executive Committee with recommendations from each clinical and/or function based committee and will be tailored according to need. Funds flow modeling & budgeting will outline a specific category for CBO's and deliverables will be assigned specific to the direct involvement & funds flow of a CBO. Clinical governance committees will outline specifics of CBO involvement as each project plan actualization plan is	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
from each clinical and/or function based committee and will be tailored according to need. Funds flow modeling & budgeting will outline a specific category for CBO's and deliverables will be assigned specific to the direct involvement & funds flow of a CBO. Clinical governance committees will outline specifics of CBO involvement as each project plan actualization plan is finalized and will make final recommendations through the Executive Committee. Individual CBO contractual agreements will be executed based on need & timing of each project and will outline and overall expectation as well as brief descriptions of all distribution year(s) expected to be engaged.		finalized and will make final recommendations through the Executive Committee. Individual CBO contractual agreements will be executed based on need & timing of each project and will outline and overall expectation as well as brief descriptions of all distribution year(s) expected to be engaged.							

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
Finalize governance structure and sub-committee structure	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.
Finalize bylaws and policies or Committee Guidelines where applicable	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	sak2047	Documentation/Certification	40_MDL0203_1_3_20160315094203_Governance_Milestone_2_&_6_Packet_03_15_16.pdf	Governance Milestone 2 & 6 DY1, Q3 Remediation Documentation	03/15/2016 09:42 AM
	cc599179	Templates	40_MDL0203_1_3_20160129133419_Clinical_Governance_Committees_Template_012616.xlsx	Clinical Governance Committees Template	01/29/2016 01:34 PM
	cc599179	Documentation/Certification	40_MDL0203_1_3_20160129132319_Committee_Charter_-_NY_DSRIP_Clinical_Integration_-_Population_Health_Management.docx	Clinical Integration Committee Charter	01/29/2016 01:23 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	cc599179	Templates	40_MDL0203_1_3_20160129132246_Meeting_Schedule_-_Clinical_Committees_012616.xlsx	Meeting Schedule - Clinical Committees	01/29/2016 01:22 PM
	cc599179	Meeting Materials	40_MDL0203_1_3_20160129132146_Executive_Committee_Agendas.pdf	Executive Committee Agendas	01/29/2016 01:21 PM
	cc599179	Documentation/Certification	40_MDL0203_1_3_20160129132056_NYPQ_Org_Charts.pptx	NYP/Q Organizational Chart	01/29/2016 01:20 PM
Establish governance structure reporting and monitoring processes	cc599179	Meeting Materials	40_MDL0203_1_3_20160129131827_Dashboard_from_Exec_Committee_Packet_121715.pdf	Executive Performance Dashboard	01/29/2016 01:18 PM
	cc599179	Meeting Materials	40_MDL0203_1_3_20160129131724_NYPQ_PPS_Executive_Committee_11_12_2015_Exec_Dashboard_Summary_ASimmons.pdf	Executive Committee Dashboard Summary	01/29/2016 01:17 PM
Finalize partnership agreements or contracts with CBOs	sak2047	Documentation/Certification	40_MDL0203_1_3_20160315094439_Governance_Milestone_2_&_6_Packet_03_15_16.pdf	Governance Milestone 2 & 6 DY1, Q3 Remediation Documentation	03/15/2016 09:44 AM
	cc599179	Contracts and Agreements	40_MDL0203_1_3_20160129131546_NYPQ_Provider_Collaboration_Agreement_-_FINAL_12.22.2015.pdf	Provider Collaboration Agreement	01/29/2016 01:15 PM
	cc599179	Contracts and Agreements	40_MDL0203_1_3_20160129131528_NYPQ_BAA_0715.pdf	BAA	01/29/2016 01:15 PM
	cc599179	Contracts and Agreements	40_MDL0203_1_3_20160129131407_Funds_Flow_Addendum_FINAL_12.22..2015.pdf	Funds Flow Addendum	01/29/2016 01:14 PM
	cc599179	Contracts and Agreements	40_MDL0203_1_3_20160129131344_BAA_Addendum_-_DSRIP.pdf	BAA Addendum	01/29/2016 01:13 PM
	cc599179	Meeting Materials	40_MDL0203_1_3_20160129130937_CBO_Contracting_Plan_for_Exec_Approval.docx	List of CBOs for Contracting Plan	01/29/2016 01:09 PM
	cc599179	Templates	40_MDL0203_1_3_20160129130831_Meeting_Schedule_-_Governance_012816.xlsx	Meeting Schedule - Governance	01/29/2016 01:08 PM
	cc599179	Templates	40_MDL0203_1_3_20160129130737_CBO_Template_012616.xlsx	CBO Template	01/29/2016 01:07 PM
Inclusion of CBOs in PPS Implementation.	cc599179	Templates	40_MDL0203_1_3_20160129130034_CBO_Template_012616.xlsx	CBO Template	01/29/2016 01:00 PM
	cc599179	Meeting Materials	40_MDL0203_1_3_20160129125949_Executive_Committee_Agendas_(CBO).pdf	Executive Committee Agendas - November and December 2015	01/29/2016 12:59 PM

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	
Finalize bylaws and policies or Committee Guidelines where applicable	
Establish governance structure reporting and monitoring processes	
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	
Finalize partnership agreements or contracts with CBOs	PPS Changed the end date for this milestone per the IA remediation feedback.
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.)	
Finalize workforce communication and engagement plan	Task 2 end date changed to 2/15/16 to align with the completion of the communication plan. Task 5: Task should reflect that the town hall meetings will be held bi-annually instead of quarterly Task 7 end date moved to 3/31/16 to align with communication plan completion date
Inclusion of CBOs in PPS Implementation.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Complete	
Milestone #2	Pass & Complete	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Complete	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #9	Pass & Complete	

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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.

Risk 1...Maintain all participating parties engaged in the process throughout the long-term, including governance members, providers, and stakeholders.
Mitigation...Promote continuous engagement through several initiatives which
consist of inclusion, two-way communication, financial incentives where appropriate for performance, and formal recognition of best practices and engagement. The PPS will also continue to partner with bordering PPS lead entities in order to plan collaboratively and identify issues as clinical programs are implemented and funds flow models are established.

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.)

The Governing structure is the core foundation of the NYHQ PPS collaborative model and will set initial and long term expectations of our projects and partners to collectively affect our patient population. This structure is critical to the success of all work streams as it will be the authority figure of the PPS to provide guidance, approvals, strategy, and accountability for all involved. Governance will be supported by all function based workflows such as Finance, IT, Performance Reporting, etc. and will be successful based on effective implementation of structure and accountability of all workflows.

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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.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Chair	Maureen Buglino - NYP/Q	Provide leadership and strategic direction to the committee ensuring a focus to the DSRIP mission and deliverables Act as the primary point-of-contact to the Lead Applicant for progress, performance, or risk reporting Ensure collaboration & transparency among all PPS partners
Vice-Chair & Member - Clinical Integration	Anthony Somogyi, MD - Chairman of Community Medicine NYP/Q	Partner with the Chair, Secretary & Members to accomplish deliverables outlined in the Executive Committee Charter or DSRIP deliverable schedule Provide updates & feedback pertaining to Clinical Integration Perform Chair responsibilities when Chair is not present
Secretary	Maria D'Urso - NYP/Q	Perform duties as any other stated Member Maintain records & minutes of Executive Committee meetings Ensure adherence to voting processes & policies set forth by the Executive Committee
Member - IT Committee	Kenneth Ong, MD- NYP/Q	Active participant in the Executive Committee Provide updates & feedback pertaining to IT & Reporting Engage in strategic planning, decision making, and conflict resolution of all DSRIP projects or functions
Member - Finance Committee	Frank Hagan- NYP/Q	Active participant in the Executive Committee Provide updates & feedback pertaining to Finance, Budget, Funds Flow, Revenue Risk & Outcomes

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		Engage in strategic planning, decision making, and conflict resolution of all DSRIP projects or functions
Member- Workforce Committee	Lorraine Orlando - NYP/Q	Active participant in the Executive Committee Provide updates & feedback pertaining to Workforce Engage in strategic planning, decision making, and conflict resolution of all DSRIP projects or functions
Member - Long Term Care	Mike Tretola, Silvercrest	Active participant in the Executive Committee Provide updates & feedback specific to Long Term care initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the Executive Committee Engage in strategic planning, decision making, and conflict resolution of all DSRIP projects or functions
Member - Long Term Care	Daniel Muskin, The Grand Nursing Home (Formerly the Queens Center for Nursing Rehab)	Provide updates & feedback specific to Long Term care initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the Executive Committee Engage in strategic planning, decision making, and conflict resolution of all DSRIP projects or functions
Member - Behavioral Health	John Lavin, MHPWQ	Active participant in the Executive Committee Provide updates & feedback specific to Behavioral Health initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the Executive Committee Engage in strategic planning, decision making, and conflict resolution of all DSRIP projects or functions
Member - CBO	Paul Vitale - QCCP	Active participant in the Executive Committee

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		Provide updates & feedback specific to Community Based Organizations, market dynamics, or community happenings Become a liaison between the partner & provider community & the Executive Committee Engage in strategic planning, decision making, and conflict resolution of all DSRIP projects or functions
Member - Home Care	Faivish Pewzner, Americare	Active participant in the Executive Committee Provide updates & feedback specific to Community Based Organizations, market dynamics, or community happenings Become a liaison between the partner & provider community & the Executive Committee Engage in strategic planning, decision making, and conflict resolution of all DSRIP projects or functions
Ex-Officio Member	Ashook Ramsaran - PAC Member	Advise Executive Committee of PAC feedback or questions Non-voting member of the Executive Committee Provide ongoing feedback of project implementation & provide guidance to forecasted risks

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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.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
PAC	Ex-Officio Member of Executive Committee (Ashook Ramsaran) Provide insight to the committee of a partner perspective on project implementation, budget, IT, etc.	Advise on project development and forecasted risks
PPS Providers & Organizations	Seats on Executive Committee Provide input into the committee to all aspects of the PPS and projects	Advise on project development, forecasted risks, and provider engagement related issues
Community Based Organizations Examples of CBOs to be engaged include: the Asthma Coalition of Queens, Catholic Charities, Self-help Community Services, Silvercrest Housing	Seat on Executive Committee Provide input into the committee to all aspects of the PPS and projects	Advise on community need regarding non-clinical services
External Stakeholders		
Community Stakeholders	Directly influenced by projects Open access to the Executive Committee	Provide advice and pulse of the community
1199TEF	Directly influenced by projects Open access to the Executive Committee	Provide expertise and regulations related to union employees
Political Officials & Departments	Indirectly influenced by projects or PPS Open access to Executive Committee	Partner to provide feedback regarding community or political climate or initiatives
Bordering PPS's	Directly influenced by projects Open access to the Executive Committee	Create a collaborative crossing PPS boundaries that encourages synergy and transparency to effectively implement & manage DSRIP programs

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 of a shared IT infrastructure across NYHQ PPS will be an indirect support of the Governance work stream as it is mission critical for the success of our projects and functions but not direct in the sense that this work stream will not directly utilize the functionality of the patient IT infrastructure. With a collaborative model, the focus of the IT infrastructure will be shared patient information with a focus to the success implementation of 9 projects with outcomes specific to milestones, metrics, and project requirements (patient-centric versus organizational function).

Specific to the IT infrastructure of the Governance structure, Performance Logic has been purchased by the PMO to track milestones/tasks/metrics/outcomes/data to include those identified above. All committee & sub committee tasks, agendas, and notes will be housed in this tool to ensure communication with the PMO & levels of accountability for outcomes.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

The NYHQ Project Management Office will utilize a project management tool(s), Performance Logic, that will manage milestone & key step level deliverables with assigned due dates. The PMO tool will be constructed utilizing the Implementation Plan, Project Requirements, & Metrics and align with workflows &/or project committees and/or actualization plans in order to provide real-time progress updates that will be distributed through the governing structure to provide progress & accountability reports. The system will be built with functionality and ease of reporting as the primary focus to ensure strong transparent reporting from all committees and the PMO. An escalation schedule will be implemented to quickly identify risks or trends by project or function by expected deliverable & due date. The reporting package(s) will be utilized throughout the PPS and will allow committees access to critical data to ensure success.

The success of this work stream will be measured by the tracking of all milestones & tasks with associated timelines with accountability directly linked to the PMO, Committee, or sub committee. The tracking and accountability will be managed by the PMO Executive Leader.

IPQR Module 2.9 - IA Monitoring

Instructions :

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1...Confirm Finance Committee membership assignments / a. Prepare Organizational Chart that defines relationships between Finance and other PPS governing functions	Completed	Step 1...Confirm Finance Committee membership assignments / a. Prepare Organizational Chart that defines relationships between Finance and other PPS governing functions	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2...Draft Committee charter w/ responsibilities & reporting structure / a. Present overview of Finance functions, membership and organization to providers and internal stakeholders	Completed	Step 2...Draft Committee charter w/ responsibilities & reporting structure / a. Present overview of Finance functions, membership and organization to providers and internal stakeholders	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3... Obtain PPS Executive Committee approval	Completed	Step 3... Obtain PPS Executive Committee approval	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	In Progress	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 financial indicators: days cash	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers							
Task Step 1…Finance Committee to draft process for routine collection of network partners' financials / a. Select metrics, consistent with industry standards, to measure the relative financial health of networks partners; establish baseline positions from initial screen	Not Started	Step 1…Finance Committee to draft process for routine collection of network partners' financials / a. Select metrics, consistent with industry standards, to measure the relative financial health of networks partners; establish baseline positions from initial screen	12/01/2015	03/01/2016	12/01/2015	03/01/2016	03/31/2016	DY1 Q4	
Task Step 2…PMO Financial Analyst to perform ongoing screening of financials to identify fragile partners with metrics approved by the finance committee / a. Identify fragile and distressed providers; monitor status quarterly for early warning signals	In Progress	Step 2…PMO Financial Analyst to perform ongoing screening of financials to identify fragile partners with metrics approved by the finance committee / a. Identify fragile and distressed providers; monitor status quarterly for early warning signals	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3…Finance Committee to draft mitigation strategies/solutions to address financial issues	In Progress	Step 3…Finance Committee to draft mitigation strategies/solutions to address financial issues	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4...Obtain PPS Executive Committee approval to implement mitigation strategies	Not Started	Step 4...Obtain PPS Executive Committee approval to implement mitigation strategies	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5...CFO & Finance Committee to implement strategies / mitigation / a. Establish a reserve sub fund to rescue/subsidize the sustainability of financially challenged/fragile network providers	Not Started	Step 5...CFO & Finance Committee to implement strategies / mitigation / a. Establish a reserve sub fund to rescue/subsidize the sustainability of financially challenged/fragile network providers	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1...Establish Audit & Compliance Committee membership and charter	Completed	Step 1...Establish Audit & Compliance Committee membership and charter	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2...Draft policies/procedures for a NY363-d	Completed	Step 2...Draft policies/procedures for a NY363-d PPS compliance plan	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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PPS compliance plan									
Task Step 3…Establish metrics for audit process & dashboard to be reported to the Audit & Compliance Committee quarterly	Completed	Step 3…Establish metrics for audit process & dashboard to be reported to the Audit & Compliance Committee quarterly	10/01/2015	11/30/2015	10/01/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Step 4…Obtain Executive Committee approval of the PPS compliance plan & reporting dashboards & process	Completed	Step 4…Obtain Executive Committee approval of the PPS compliance plan & reporting dashboards & process	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5...Confirm that PPS network providers have compliance plans	Completed	Step 5...Confirm that PPS network providers have compliance plans	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 6...Implement compliance plan	Completed	Step 6...Implement compliance plan	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Sub-Milestone 1: Establish Value Based Payment Work Group and Initiate Engagement / Step 1… Create VBP Workgroup with representation from a variety of PPS providers	Completed	Sub-Milestone 1: Establish Value Based Payment Work Group and Initiate Engagement / Step 1… Create VBP Workgroup with representation from a variety of PPS providers	09/01/2015	10/31/2015	09/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task Sub-Milestone 1: Establish Value Based Payment Work Group and Initiate Engagement / Step 2…Develop Charter & Membership for VBPWG	Completed	Sub-Milestone 1: Establish Value Based Payment Work Group and Initiate Engagement / Step 2…Develop Charter & Membership for VBPWG	07/01/2015	09/01/2015	07/01/2015	09/01/2015	09/30/2015	DY1 Q2	
Task Sub-Milestone 1: Establish Value Based Payment Work Group and Initiate Engagement / Step 3…VBPWG to develop communication plan & education materials for providers to facilitate	Not Started	Sub-Milestone 1: Establish Value Based Payment Work Group and Initiate Engagement / Step 3…VBPWG to develop communication plan & education materials for providers to facilitate	11/01/2015	12/31/2015	01/15/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone 2: Conduct Stakeholder	Not Started	Sub-Milestone 2: Conduct Stakeholder Engagement with PPS Providers / Step 1…VBPWG to implement communication &	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Engagement with PPS Providers / Step 1… VBPWG to implement communication & education plan for PPS partners		education plan for PPS partners							
Task Sub-Milestone 2: Conduct Stakeholder Engagement with PPS Providers / Step 2… VBPWG to develop strategy for surveying PPS partners to determine baseline assessment	Not Started	Sub-Milestone 2: Conduct Stakeholder Engagement with PPS Providers / Step 2…VBPWG to develop strategy for surveying PPS partners to determine baseline assessment	01/01/2016	02/28/2016	01/01/2016	02/28/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone 2: Conduct Stakeholder Engagement with PPS Providers / Step 3… VBPWG to create and release survey for baseline assessment on VBP to PPS partners	Not Started	Sub-Milestone 2: Conduct Stakeholder Engagement with PPS Providers / Step 3… VBPWG to create and release survey for baseline assessment on VBP to PPS partners	03/01/2016	03/31/2016	03/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone 2: Conduct Stakeholder Engagement with PPS Providers / Step 4… VBPWG to compile stakeholder VBP baseline assessment survey results and analyze findings	Not Started	Sub-Milestone 2: Conduct Stakeholder Engagement with PPS Providers / Step 4… VBPWG to compile stakeholder VBP baseline assessment survey results and analyze findings	03/01/2016	03/31/2016	03/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone 3: Conduct Stakeholder Engagement with MCOs / Step 1… VBPWG to conduct stakeholder engagement sessions with MCOs to understand potential contracting options and PPS options	Not Started	Sub-Milestone 3: Conduct Stakeholder Engagement with MCOs / Step 1… VBPWG to conduct stakeholder engagement sessions with MCOs to understand potential contracting options and PPS options	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone 4: Finalize PPS VBP Baseline Assessment / Step 1…VBPWG to submit the VBP baseline assessment to the Finance Committee for approval	Not Started	Sub-Milestone 4: Finalize PPS VBP Baseline Assessment / Step 1…VBPWG to submit the VBP baseline assessment to the Finance Committee for approval	01/01/2016	02/28/2016	01/01/2016	02/28/2016	03/31/2016	DY1 Q4	
Task Sub-Milestone 4: Finalize PPS VBP Baseline Assessment / Step 2… Executive Committee to approval VBP Baseline Assessment	Not Started	Sub-Milestone 4: Finalize PPS VBP Baseline Assessment / Step 2… Executive Committee to approval VBP Baseline Assessment	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the	Not Started	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
waiver at the latest									
Task Sub-Milestone 1: Prioritize potential opportunities and providers for VBP arrangements / Step 1… VBPWG to analyze total cost of care data from NYS DOH and other relevant agencies to identify opportunities related to VBP, including Integrated Primary Care (IPC) and ACO upside-only shared savings model (UOSSM)	Not Started	Sub-Milestone 1: Prioritize potential opportunities and providers for VBP arrangements / Step 1…VBPWG to analyze total cost of care data from NYS DOH and other relevant agencies to identify opportunities related to VBP, including Integrated Primary Care (IPC) and ACO upside-only shared savings model (UOSSM)	01/01/2016	08/01/2016	01/01/2016	08/01/2016	09/30/2016	DY2 Q2	
Task Sub-Milestone 1: Prioritize potential opportunities and providers for VBP arrangements / Step 2… VBPWG to identify accelerators and challenges related to the implementation of the UOSSM and IPC models, including existing pay for performance experience, existing and planned ACO programs and other MCO models with current incentive performance elements, and infrastructural requirements including IT, contracting and population health sophistication	Not Started	Sub-Milestone 1: Prioritize potential opportunities and providers for VBP arrangements / Step 2…VBPWG to identify accelerators and challenges related to the implementation of the UOSSM and IPC models, including existing pay for performance experience, existing and planned ACO programs and other MCO models with current incentive performance elements, and infrastructural requirements including IT, contracting and population health sophistication	01/01/2016	10/01/2016	01/01/2016	10/01/2016	12/31/2016	DY2 Q3	
Task Sub-Milestone 1: Prioritize potential opportunities and providers for VBP arrangements / Step 3… VBPWG to utilize VBP Baseline Assessment (Milestone 4) to determine partners that are best prepared to engage in identified VBP	Not Started	Sub-Milestone 1: Prioritize potential opportunities and providers for VBP arrangements / Step 3…VBPWG to utilize VBP Baseline Assessment (Milestone 4) to determine partners that are best prepared to engage in identified VBP	01/01/2016	10/01/2016	01/01/2016	10/01/2016	12/31/2016	DY2 Q3	
Task Sub-Milestone 1: Prioritize potential opportunities and providers for VBP arrangements / Step 4… VBPWG to host engagement session between partners (determine in Step 3) and MCOs to discuss process & requirements for engaging in VBP	Not Started	Sub-Milestone 1: Prioritize potential opportunities and providers for VBP arrangements / Step 4…VBPWG to host engagement session between partners (determine in Step 3) and MCOs to discuss process & requirements for engaging in VBP	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Sub-Milestone 2: Develop VBP Adoption Plan / Step 1…VBPWG to develop timeline for adoption	Not Started	Sub-Milestone 2: Develop VBP Adoption Plan / Step 1… VBPWG to develop timeline for adoption of VBP for PPS partners, ensuring utilization of the baseline analysis and cost	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
of VBP for PPS partners, ensuring utilization of the baseline analysis and cost of care analysis		of care analysis							
Task Sub-Milestone 2: Develop VBP Adoption Plan / Step 2…VBPWG to draft VBP Adoption Plan for PPS partners to include analyzing provider and PPS performance, proposing methods of dispersing shared savings and building infrastructure required to support performance monitoring and reporting	Not Started	Sub-Milestone 2: Develop VBP Adoption Plan / Step 2… VBPWG to draft VBP Adoption Plan for PPS partners to include analyzing provider and PPS performance, proposing methods of dispersing shared savings and building infrastructure required to support performance monitoring and reporting	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Sub-Milestone 2: Develop VBP Adoption Plan / Step 3…VBPWG to present VBP Adoption Plan to Finance Committee	Not Started	Sub-Milestone 2: Develop VBP Adoption Plan / Step 3… VBPWG to present VBP Adoption Plan to Finance Committee	07/01/2016	08/31/2016	07/01/2016	08/31/2016	09/30/2016	DY2 Q2	
Task Sub-Milestone 2: Develop VBP Adoption Plan / Step 4…Executive Committee to approve VBP Adoption Plan	Not Started	Sub-Milestone 2: Develop VBP Adoption Plan / Step 4… Executive Committee to approve VBP Adoption Plan	10/01/2016	11/30/2016	10/01/2016	11/30/2016	12/31/2016	DY2 Q3	
Task Sub-Milestone 2: Develop VBP Adoption Plan / Step 5…Present VBP Adoption Plan to PPS Partners and PAC	Not Started	Sub-Milestone 2: Develop VBP Adoption Plan / Step 5… Present VBP Adoption Plan to PPS Partners and PAC	11/01/2016	12/31/2016	11/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	Not Started		04/01/2016	03/31/2020	04/01/2016	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	Not Started		04/01/2017	03/31/2020	04/01/2017	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	Not Started		04/01/2018	03/31/2020	04/01/2018	03/31/2020	03/31/2020	DY5 Q4	YES

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description
Finalize PPS finance structure, including reporting structure	If there have been changes, please describe those changes and upload any supporting documentation as necessary.	Please state if there have been any changes during this reporting quarter. Please state yes or no in the corresponding narrative box.

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	sak2047	Documentation/Certification	40_MDL0303_1_3_20160111113603_NYPQ_Compliance_Certification.pdf	Compliance Plan Certification	01/11/2016 11:36 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	PPS has changed task 3 to the following: PPS Executive Committee will reverie quarterly updates from the PPS Compliance Officer
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Sub-Milestone 1, Step 3- PPS has chnaged the start and end date of this task to align with the collaborative process with NYP PPS and the kick-off of the VBP workgroup in 2016
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Complete	

NYS Confidentiality – High

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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.

Risk 1...Create a common understanding among the network providers about the changing reimbursement environment
Mitigation....Host education sessions and ensure partner engagement in the transition process from FFS to VBP

Risk 2...Successful transition from FFS to VBP with MCOs
Mitigation...PPS will leverage tools provided by NYS, ie VBP roadmap, to determine strategic plan for engaging MCOs in this process

Risk 3...Partner dis-engagement from DSRIP due to incentive payments being linked to a PPS wide performance system and not an individual performance system
Mitigation...Provide PMO support and appropriate tools to ensure participation and engagement and work with the Practitioner Engagement sub-committee to ensure continued engagement

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.)

In many respects, the Financial Sustainability function is the glue that ties together all of the PPS workstreams, converting clinical and service activities into performance data and incentive distributions. Governance will depend on utilization and financial reporting to focus its guidance. Workforce activities will be gauged on relative demand and productivity measures. IT Systems/Processes will be designed to produce financial reporting requirements. Population Health will be measured to reflect utilization and financial consumption. Clinical Integration will be measured by its increases in productivity. Practitioner Engagement will be coordinated to align efforts to maximized economic incentives. Performance Reporting will detail how well all of these functions achieved their objectives.

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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.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Finance Committee - PPS PMO Executive Leadership	Maureen Buglino & Maria D'Urso, NYP/Q	Responsible for development and management of the PMO Finance function, including functional roles (AR, AP, treasury, etc.), subject matter experts, financial analysts, reporting resources, consultants (as needed) and supporting IT. The PMO will provide guidance and oversight related to the Financial Stability Plan.
PPS Finance Committee - Chair and Vice Chair	Frank Hagan & Chris Caulfield, NYP/Q	Responsible for the leadership and management of the PPS Finance Committee in its role in overseeing PPS Network Member financial sustainability, including adoption of thresholds, standards and framework.
Finance Committee - Compliance Officer	Deborah Marsden, NYP	Will oversee the development and implementation of the compliance plan of the PPS Lead and related compliance requirements of the PPS as they are defined. Scope would include the PPS Lead compliance plan related to DSRIP. The PPS Lead - Compliance will advise the Executive Committee.
Finance Committee - Audit	Chris Caulfield, NYP/Q	Engages and oversees internal and/or external auditors reporting to the Compliance/Audit Committee who will perform the audit of the PPS related to DSRIP services according to the audit plan recommended by the PPS Compliance/Audit Committee and approved by the PPS Finance Committee and Committees.
Finance Committee - Members	William O'Hara, Chapin Home Michael Tretola, Silvercrest Felix Rosado, Americare Evan Zuckerman, Brightpoint Health Debra Timms, MHPWQ Ropo Oyebode, Elmcor Youth & Family Alan Wengrofsky, Community Health Network	Actively participate in committee discussions & decision making. Become a liaison between the committee and partnering organizations or providers to provide updates regarding progress or policies.
Finance Committee - Value Based Payment MCO Member	Lauren Marino, NYP/Q	Partner with committee members & clinical sub committees to outline plans for achieving VBP plans for partners.

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IPQR Module 3.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Mark Greaker, NYP/Q	IT/PR Committee Vice Chair	Information Technology related requirements for the finance function; access to data for the finance function reporting requirements
Lorraine Orlando, NYP/Q	Workforce Committee Vice Chair	Workforce related requirements, including training budget, for the finance function
Deborah Marsden, NYP	Audit Committee Chair	Oversight of compliance plan development, implementation and enforcement
Various Executive Committee Member (Rotating)	Executive Committee	Oversight of PPS Finance and Audit Committee recommendations; review of VBP Adoption Plan
External Stakeholders		
Various PAC Member (Rotating)	PAC	Communication of community needs and interests related to network financial sustainability and compliance
MCOs and other payers, including special needs plans	VBPWG	Productive engagement with the PPS VBPWG
PPS Partners	PPS Partner Organizations & Providers	Inform committee of financial needs and make recommendations on uncovered services for VBP transition
NYS DOH	Defines related DSRIP requirements	Timely, exhaustive requirements; robust support for fulfilling; and easy access to enabling data, technology and other tools

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.

The PPS will implement standardized monthly reporting expectations for all workflows utilizing consistent tools (Performance Logic) and reports that outline expectations to the project, milestone, metric, and requirement level. Reporting will be a bottom-up model that feeds directly from patients, providers, and staff and will be leveraged as an accountability tool for the Executive Committee. A project management tool, Performance Logic, has been contracted and is in the implementation phase for all aspects of the PPS.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

The success of the Financial Sustainability workstream will ultimately be measured on how well it designs and implements the PPS performance and financial reporting system. To the extent that the PPS network participants and PPS organizational functions receive timely, comprehensive and accurate measurements of utilization, resource consumption, productivity, quality, etc., then the financial functions will have accomplished its objective.

IPQR Module 3.9 - IA Monitoring

Instructions :

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	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.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1... PMO Executive to establish a committee structure to coordinate, oversee and align PPS cultural competency, health literacy and community engagement structures, processes and interventions.	Completed	Step 1... PMO Executive to establish a committee structure to coordinate, oversee and align PPS cultural competency, health literacy and community engagement structures, processes and interventions.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2... PMO Executive to use the pre-existing 24 member multi-ethnic, Community Advisory Council (CAC) as a liaison and to target specific ethnic communities and areas of high	Completed	Step 2... PMO Executive to use the pre-existing 24 member multi-ethnic, Community Advisory Council (CAC) as a liaison and to target specific ethnic communities and areas of high concentration for those groups	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
concentration for those groups									
Task Step 3…Cultural Competency Committee & Clinical sub committee to identify existing linguistically appropriate patient assessments and tools within PPS and determine needs for new/updated documents based on PPS CNA	Completed	Step 3…Cultural Competency Committee & Clinical sub committee to identify existing linguistically appropriate patient assessments and tools within PPS and determine needs for new/updated documents based on PPS CNA	08/01/2015	11/30/2015	08/01/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Step 4... Cultural Competency Committee to develop the cultural competency / health literacy strategy based on recommendations from PPS CNA, CAC, and partner organizations & providers	Completed	Step 4... Cultural Competency Committee to develop the cultural competency / health literacy strategy based on recommendations from PPS CNA, CAC, and partner organizations & providers	08/01/2015	10/01/2015	08/01/2015	10/01/2015	12/31/2015	DY1 Q3	
Task Step 5…Committee Chair to submit the Cultural Competency & Health Literacy Strategy to the Executive Committee for approval	Completed	Step 5…Committee Chair to submit the Cultural Competency & Health Literacy Strategy to the Executive Committee for approval	10/01/2015	11/01/2015	10/01/2015	11/01/2015	12/31/2015	DY1 Q3	
Task Step 6…Cultural Comp Chair to present strategy to PAC	Completed	Step 6…Cultural Comp Chair to present strategy to PAC	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7… PMO Executive & Committee Chair to utilize Community Advisory Counsel, patient representatives, and PPS partners to provide ongoing feedback on the cultural competency & health literacy strategy. Committee to update the strategy and relevant documents as needed based on feedback received.	Completed	Step 7… PMO Executive & Committee Chair to utilize Community Advisory Counsel, patient representatives, and PPS partners to provide ongoing feedback on the cultural competency & health literacy strategy. Committee to update the strategy and relevant documents as needed based on feedback received.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
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	09/01/2015	06/30/2016	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		and effective patient engagement approaches							
Task Step 1... PMO Executive & Committee Chair to identify approaches and best practices for cultural competency & health literacy training strategy	In Progress	Step 1... PMO Executive & Committee Chair to identify approaches and best practices for cultural competency & health literacy training strategy	10/01/2015	12/31/2015	10/01/2015	02/05/2016	03/31/2016	DY1 Q4	
Task Step 2... Committee Chair & Workforce Chair to analyze current workforce readiness including the current cultural competency training programs and the best practices for incorporating updated training into the expectations for the PPS partners and staff	Not Started	Step 2... Committee Chair & Workforce Chair to analyze current workforce readiness including the current cultural competency training programs and the best practices for incorporating updated training into the expectations for the PPS partners and staff	10/01/2015	01/31/2016	01/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Step 3…Committee to utilize PPS CNA to inform the cultural competency & health literacy training strategy to focus on drivers of health disparities specific to the Queens population	Not Started	Step 3…Committee to utilize PPS CNA to inform the cultural competency & health literacy training strategy to focus on drivers of health disparities specific to the Queens population	10/01/2015	01/31/2016	01/01/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Step 4... Committee Chair & Workforce Chair to create the training strategy to incorporate cultural sensitivity into daily work practices while incorporating industry best practices to ensure high quality service to all patients among all of the partner institutions	Not Started	Step 4... Committee Chair & Workforce Chair to create the training strategy to incorporate cultural sensitivity into daily work practices while incorporating industry best practices to ensure high quality service to all patients among all of the partner institutions	01/31/2016	04/30/2016	01/31/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Step 5... Communication team to create a communication plan for the training strategy for PPS partners and staff	Not Started	Step 5... Communication team to create a communication plan for the training strategy for PPS partners and staff	01/31/2016	04/30/2016	01/31/2016	04/30/2016	06/30/2016	DY2 Q1	
Task Step 6... Committee Chair to submit the Training Strategy and communication plan to the PPS Executive Committee for approval	Not Started	Step 6... Committee Chair to submit the Training Strategy and communication plan to the PPS Executive Committee for approval	04/01/2016	05/31/2016	04/01/2016	05/31/2016	06/30/2016	DY2 Q1	
Task Step 7…Committee Chair & PMO Executive to present plan to PAC	Not Started	Step 7…Committee Chair & PMO Executive to present plan to PAC	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	sak2047	Documentation/Certification	40_MDL0403_1_3_20160315145055_CCHL_Milestone_1_Packet_03_12_16.pdf	CCHL Milestone 1 DY1, Q3 Remediation Documents	03/15/2016 02:50 PM
	cc599179	Templates	40_MDL0403_1_3_20160129123247_Meeting_Schedule_-_Cultural_Competency_and_Health_Literacy_012616.xlsx	Meeting Schedule - Cultural Competency & Health Literacy	01/29/2016 12:32 PM
	cc599179	Templates	40_MDL0403_1_3_20160129123159_Training_Template_-_Not_Started_Yet.docx	Training Template - Not Started Yet	01/29/2016 12:31 PM
	sak2047	Documentation/Certification	40_MDL0403_1_3_20160113143115_CCHL_Strategy_FINAL.pdf	CCHL Strategy	01/13/2016 02:31 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Complete	
Milestone #2	Pass & Ongoing	

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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.

Risk 1...possible imbalance of focus for cultural makeup of the community and how to address the various cultural components of the community equally with program funding
Mitigation...PPS will identify sustainable funding for key programs addressing health disparities, appoint subcommittees that will represent each identified group to ensure balance in project planning and development

Risk 2....CBOs may not currently have the bandwidth to support the implementation of a PPS wide training strategy
Mitigation...PPS will work with the CBOs to create a collaborative plan and ensure a reasonable roll out schedule for PPS wide cultural competency training

Risk 3...engaging the patients in the health literacy strategy of the PPS- patient engagement will be key to the success of the cultural competency & health literacy work flow
Mitigation...PPS will collaborate with CBOs to engage patients across the PPS. Additionally, the training of PPS staff in cultural competency & health literacy will aid in the patient engagement aspect portion of the success of this workstream

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.)

Cultural competency and health literacy strategies applies to and influences all DSRIP projects and will be embedded into all project planning and implementation plans. Planning and executing the training strategy will be coordinated with the Workforce workstream to leverage existing training resources and infrastructure and to track training participation and completion. Governance will oversee project milestone attainment, Practitioner Engagement sessions for cultural competency will be integrated into the implementation plans. Financial funding will be needed for sustainability of projects. IT interoperability will have a major impact on this stream, refer to IT component.

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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.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Cultural Competency Committee, Chair	Helen Lavas, NYP/Q	Manage Cultural Comp. & Health Lit. Committee to ensure completion of Milestones Ensure transparency & collaboration among all partners Present monthly/quarterly updates to the Executive Committee regarding developments
Cultural Competency Committee, Vice Chair	Medina Kurtovic, NYP/Q	Provide support to the Chair and Committee as a lead role Ensure progression of discussions & planning to ensure successful deliverable completion
Cultural Competency Committee, PPS PMO Executive Leadership	Maureen Buglino & Maria D'Urso, NYP/Q	Active participant in the Cultural Competency & Health Literacy Committee; Liaison for PPS PMO
Cultural Competency Committee, Workforce Committee Representative	Rosemarie Liguigli, NYP/Q	Active participant in the Cultural Competency & Health Literacy Committee; Provide updates & feedback specific to workforce initiatives Engage in strategic planning, decision making, and conflict resolution of all DSRIP projects or functions and ensure that strategy is aligned with workforce strategy
Cultural Competency Committee, Member	Connie Tejeda, Centerlight Health System Lina Scacco, Parker Jewish Tasha Lewis, Franklin Center for Rehabilitation and Nursing John Lavin, MHPWQ Sarah McQuad, MHPWQ Jonathan Mawere, Queens Boulevard Extended Care Facility Penina Mezei, Americare Evelyn Morales, Bright Point Health Christian Valesco, NYP/Q Maddy Jacobs, SelfHelp Michelle Williams, NYP/Q	Actively participate in committee discussions & decision making Become a liaison between the committee and partnering organizations or providers to provide updates regarding progress or policies

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IPQR Module 4.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
CNO	Michaelle Williams	Resource to align clinical perspective with the cultural competency training strategy, assist with practitioner buy-in for training
Community Medicine Clinical Director	Margaret Cartmell	Resource to align clinical perspective with the cultural competency training strategy, assist with practitioner buy-in for training
Chief Learning Officer	Patricia Woods	Resource for existing training materials and implementing new training strategies
PPS Partners	All PPS Partners	Provide information for current state analysis and training needs, participate in training and provide feedback to PPS PMO
Community Advisory Council	CAC	Existing council to maximize cultural competency efforts through engagement of DSRIP
Workforce Committee Chair	Lorraine Orlando	Resource for workforce strategies & alignment with cultural competency
External Stakeholders		
CBOs	Contract for PPS Workforce Training	Contract for PPS workforce training
PPS Partners	All PPS Partners	Provide information for current state analysis and training needs, participate in training and provide feedback to PPS PMO

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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.

Information technology expectations include 1) the ability to identify and document additional socio-economic characteristics and health literacy status on intake and admissions fields to flag patient status for staff, care providers, and care givers and activate cultural competency/health literacy guidelines; 2) the ability to sort outcomes according to disparate population characteristics; and 3) use of the educational platform to offer, track and manage educational and training offerings.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

The PPS will implement standardized monthly reporting expectations for all workflows utilizing consistent tools and reports that outline expectations to the project, milestone, metric, and requirement level. Reporting will be a bottom-up model that feeds directly from patients, providers, and staff and will be leveraged as an accountability tool for the Executive Committee. A project management tool is under review and will be purchased based on finalized budget planning. In order to track the progress of this workstream, the PPS will conduct surveys of the staff regarding the success of the cultural competency training.

IPQR Module 4.9 - IA Monitoring

Instructions :

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
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).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	07/01/2015	12/31/2015	10/01/2015	02/15/2016	03/31/2016	DY1 Q4	NO
Task Step 2…Assess partners and RHIO's IT capabilities to address gaps related specific to data sharing and integration including DSRIP reporting to include: 1. Determine what data is available to support the DSRIP reporting 2. Determine what providers are connected to Healthix 3. Determine how the data is currently captured and measures would be created (e.g., central vs. individual PPS partners)	Completed	Step 2…Assess partners and RHIO's IT capabilities to address gaps related specific to data sharing and integration including DSRIP reporting to include: 1. Determine what data is available to support the DSRIP reporting 2. Determine what providers are connected to Healthix 3. Determine how the data is currently captured and measures would be created (e.g., central vs. individual PPS partners)	08/01/2015	09/15/2015	08/01/2015	09/15/2015	09/30/2015	DY1 Q2	
Task Step 3…Perform an analysis of DSRIP Project Requirements to clearly define IT needs, including member segment engagement and data needs.	Completed	Step 3…Perform an analysis of DSRIP Project Requirements to clearly define IT needs, including member segment engagement and data needs.	09/01/2015	10/01/2015	10/01/2015	10/01/2015	12/31/2015	DY1 Q3	
Task Step 4…Identify and document critical gaps in being ready to support DSRIP project IT needs.	Completed	Step 4…Identify and document critical gaps in being ready to support DSRIP project IT needs.	10/01/2015	11/01/2015	10/01/2015	11/01/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 5…Compile and document a current state assessment of IT capabilities, that includes results of the partner survey (Step 2), partner assessment (Step 3), and critical gap identification (Step 4), and defines options and high-level budget estimates to close critical gaps.	Completed	Step 5…Compile and document a current state assessment of IT capabilities, that includes results of the partner survey (Step 2), partner assessment (Step 3), and critical gap identification (Step 4), and defines options and high-level budget estimates to close critical gaps.	10/15/2015	11/15/2015	10/15/2015	11/15/2015	12/31/2015	DY1 Q3	
Task Step 6…Distribute draft current state assessment to partners to ensure accuracy and incorporate feedback into the finalized assessment.	Completed	Step 6…Distribute draft current state assessment to partners to ensure accuracy and incorporate feedback into the finalized assessment.	11/15/2015	11/30/2015	11/15/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Step 7…IT Committee reviews current state assessment and options to close critical gaps and recommends direction to guide the IT future state to the Executive Committee for approval	In Progress	Step 7…IT Committee reviews current state assessment and options to close critical gaps and recommends direction to guide the IT future state to the Executive Committee for approval	12/01/2015	12/15/2015	12/01/2015	02/12/2016	03/31/2016	DY1 Q4	
Task Step 1…Survey partners of IT capabilities (e.g., EHR/PMS adoption and Meaningful Use, Enterprise Data Warehousing and analytics, Patient Engagement Tools and Strategies, Population health tools and strategies)	Completed	Step 1…Survey partners of IT capabilities (e.g., EHR/PMS adoption and Meaningful Use, Enterprise Data Warehousing and analytics, Patient Engagement Tools and Strategies, Population health tools and strategies)	07/01/2015	08/31/2015	07/01/2015	08/31/2015	09/30/2015	DY1 Q2	
Milestone #2 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes	04/15/2015	03/31/2016	04/15/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…PPS Executive & PMO to formalize IT Committee that a includes a charter with deliverables that address change management and an IT governance change management	Completed	Step 1…PPS Executive & PMO to formalize IT Committee that a includes a charter with deliverables that address change management and an IT governance change management oversight process that includes workflows for authorizing and implementing IT changes with appropriate	04/15/2015	09/15/2015	04/15/2015	09/15/2015	09/30/2015	DY1 Q2	

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
oversight process that includes workflows for authorizing and implementing IT changes with appropriate representation on the Executive Committee		representation on the Executive Committee							
Task Step 2…IT Committee & IT PMO staff to complete a SWOT analysis that identifies hurdles of the system in order to properly define an interactive change management process	Completed	Step 2…IT Committee & IT PMO staff to complete a SWOT analysis that identifies hurdles of the system in order to properly define an interactive change management process	08/15/2015	10/01/2015	08/15/2015	10/01/2015	12/31/2015	DY1 Q3	
Task Step 3…PMO IT staff to establish a training program with a focus of EHR integration and change management and a communication plan for keeping everyone informed of progress	Not Started	Step 3…PMO IT staff to establish a training program with a focus of EHR integration and change management and a communication plan for keeping everyone informed of progress	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4	
Task Step 4…Present an IT Change Management Strategy to the IT Committee for review & approval of implementation	Not Started	Step 4…Present an IT Change Management Strategy to the IT Committee for review & approval of implementation	03/01/2016	03/15/2016	03/01/2016	03/15/2016	03/31/2016	DY1 Q4	
Task Step 5…Present IT Change Management Strategy for review & approval to the Executive Committee	Not Started	Step 5…Present IT Change Management Strategy for review & approval to the Executive Committee	03/15/2016	03/30/2016	03/15/2016	03/30/2016	03/31/2016	DY1 Q4	
Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	In Progress	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 DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		to be shared and the purpose of this sharing).							
Task Step 1…PMO Executive & IT Chair to create a governance framework with overarching rules of the road for interoperability and clinical data sharing including appropriate policies and procedures	Completed	Step 1…PMO Executive & IT Chair to create a governance framework with overarching rules of the road for interoperability and clinical data sharing including appropriate policies and procedures	08/01/2015	12/15/2015	08/01/2015	12/15/2015	12/31/2015	DY1 Q3	
Task Step 2…IT Lead to validate existing data exchange legal and compliance framework to ensure that it supports DSRIP data exchange requirements that meet patient consent needs including: care management records (complete subcontractor Data Exchange Applications and Agreement (DEAAs) with all Medicaid providers within PPS; contracts with all Community Based Organizations (CBOs) including a BAA documenting the level of Patient Health Information (PHI) to be shared and the purpose of this data sharing	Completed	Step 2…IT Lead to validate existing data exchange legal and compliance framework to ensure that it supports DSRIP data exchange requirements that meet patient consent needs including: care management records (complete subcontractor Data Exchange Applications and Agreement (DEAAs) with all Medicaid providers within PPS; contracts with all Community Based Organizations (CBOs) including a BAA documenting the level of Patient Health Information (PHI) to be shared and the purpose of this data sharing	08/01/2015	12/15/2015	08/01/2015	12/15/2015	12/31/2015	DY1 Q3	
Task Step 3…IT Committee to use current state IT Assessment and related program standards, such as PCMH & Meaningful Use standards, to develop an IT future state and roadmap of tactical and strategic recommendations that builds incrementally on existing infrastructures and support DSRIP project requirements, with high-level budget estimates and resource requirements to support data sharing and implementation of interoperable IT platform	Not Started	Step 3…IT Committee to use current state IT Assessment and related program standards, such as PCMH & Meaningful Use standards, to develop an IT future state and roadmap of tactical and strategic recommendations that builds incrementally on existing infrastructures and support DSRIP project requirements, with high-level budget estimates and resource requirements to support data sharing and implementation of interoperable IT platform	01/01/2016	02/15/2016	01/01/2016	02/15/2016	03/31/2016	DY1 Q4	
Task Step 4…Present an IT future state and roadmap to the IT Committee for review & approval of for implementation	Not Started	Step 4…Present an IT future state and roadmap to the IT Committee for review & approval of for implementation	02/15/2016	03/01/2016	02/15/2016	03/01/2016	03/31/2016	DY1 Q4	
Task Step 5…IT Chair & PMO IT staff to present IT	Not Started	Step 5…IT Chair & PMO IT staff to present IT future state and roadmap to partners to ensure accuracy & transparency	03/01/2016	03/15/2016	03/01/2016	03/15/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
future state and roadmap to partners to ensure accuracy & transparency									
Task Step 6…IT Chair to present IT future state and roadmap to partner RHIO's for review & feedback	Not Started	Step 6…IT Chair to present IT future state and roadmap to partner RHIO's for review & feedback	03/01/2016	03/15/2016	03/01/2016	03/15/2016	03/31/2016	DY1 Q4	
Task Step 7…IT Chair to seek approval of IT future state and roadmap from the Executive Committee	Not Started	Step 7…IT Chair to seek approval of IT future state and roadmap from the Executive Committee	03/01/2016	03/15/2016	03/01/2016	03/15/2016	03/31/2016	DY1 Q4	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	In Progress	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.	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1…PMO IT staff to complete a systematic review of existing tools, both qualitative and quantitative, that engage the Medicaid population of PPS partners such as patient portal(s), texting, RHIOs, and mobile technology	Completed	Step 1…PMO IT staff to complete a systematic review of existing tools, both qualitative and quantitative, that engage the Medicaid population of PPS partners such as patient portal(s), texting, RHIOs, and mobile technology	08/01/2015	09/15/2015	08/01/2015	09/15/2015	09/30/2015	DY1 Q2	
Task Step 2…PMO IT staff to define member segments and associated specific engagement needs (e.g., geo-access assessment, cultural/linguistic needs)	Completed	Step 2…PMO IT staff to define member segments and associated specific engagement needs (e.g., geo-access assessment, cultural/linguistic needs)	08/01/2015	11/30/2015	08/01/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Step 3…PMO Staff & IT Chair to determine appropriate methods and incremental technological services needed for engaging patients and delivering care including EMR & RHIO use (e.g., patient portal, text messages, and mobile technology)	Completed	Step 3…PMO Staff & IT Chair to determine appropriate methods and incremental technological services needed for engaging patients and delivering care including EMR & RHIO use (e.g., patient portal, text messages, and mobile technology)	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4…IT Chair to present findings to the IT Committee of the existing tools with recommendations of improvements or implementations to include financial implications	Not Started	Step 4…IT Chair to present findings to the IT Committee of the existing tools with recommendations of improvements or implementations to include financial implications and project alignment	02/15/2016	03/01/2016	02/15/2016	03/01/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
and project alignment									
Task Step 5…IT Committee to define and publish a patient engagement plan (e.g., outreach strategies, patient portals, call centers, etc.,) for PPS engagement of attributed members specific to patient, project and partner need that includes defining patient engagement metrics	Not Started	Step 5…IT Committee to define and publish a patient engagement plan (e.g., outreach strategies, patient portals, call centers, etc.,) for PPS engagement of attributed members specific to patient, project and partner need that includes defining patient engagement metrics	03/01/2016	06/01/2016	03/01/2016	06/01/2016	06/30/2016	DY2 Q1	
Task Step 6…IT Committee to work with Cultural Competency Committee to develop appropriate, multi-lingual patient education materials and content and disseminate using appropriate communication methods (e.g. Patient portal, text messages)	Not Started	Step 6…IT Committee to work with Cultural Competency Committee to develop appropriate, multi-lingual patient education materials and content and disseminate using appropriate communication methods (e.g. Patient portal, text messages)	03/01/2016	06/01/2016	03/01/2016	06/01/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop a data security and confidentiality plan.	In Progress	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.	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…PMO IT staff participating in clinical sub committees will define PPS data needs, including protected data and establishing PPS-wide protocols for protected data, including data collection, data exchange, data use, data storage, and data disposal policies with 2-factor authentication processes	Completed	Step 1…PMO IT staff participating in clinical sub committees will define PPS data needs, including protected data and establishing PPS-wide protocols for protected data, including data collection, data exchange, data use, data storage, and data disposal policies with 2-factor authentication processes	08/01/2015	09/15/2015	08/01/2015	09/15/2015	09/30/2015	DY1 Q2	
Task Step 2…PMO Executive & IT Chair to identify additional business agreements required for successful IT interoperability and clinical integration across the PPS	Completed	Step 2…PMO Executive & IT Chair to identify additional business agreements required for successful IT interoperability and clinical integration across the PPS	08/01/2015	12/01/2015	08/01/2015	12/01/2015	12/31/2015	DY1 Q3	
Task Step 3…PMO IT staff to assess IT security of all partners	In Progress	Step 3…PMO IT staff to assess IT security of all partners	08/01/2015	11/15/2015	08/01/2015	01/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 4…IT Chair to develop a data security & confidentiality plan that includes monitoring and auditing of PPS-wide protocols for protected data	Not Started	Step 4…IT Chair to develop a data security & confidentiality plan that includes monitoring and auditing of PPS-wide protocols for protected data	02/15/2016	03/01/2016	02/15/2016	03/01/2016	03/31/2016	DY1 Q4	
Task Step 5…IT Chair to present IT Committee and Executive Committee with recommendations of security enhancements with financial implications	Not Started	Step 5…IT Chair to present IT Committee and Executive Committee with recommendations of security enhancements with financial implications	03/01/2016	03/15/2016	03/01/2016	03/15/2016	03/31/2016	DY1 Q4	
Task Step 6…IT Committee to communicate the approved IT security plan to all PPS partners & PAC	Not Started	Step 6…IT Committee to communicate the approved IT security plan to all PPS partners & PAC	03/01/2016	03/15/2016	03/01/2016	03/15/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a data security and confidentiality plan.	sak2047	Documentation/Certification	40_MDL0503_1_3_20160315142549_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PS_Family)_-_REMIDIATED.docx	PS Family Workbook- DY1, Q3 Remediation Document	03/15/2016 02:25 PM
	sak2047	Documentation/Certification	40_MDL0503_1_3_20160315142455_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PE_Family)_-_REMEDIATED.docx	PE Family Workbook- DY1, Q3 Remediation Document	03/15/2016 02:24 PM
	sak2047	Documentation/Certification	40_MDL0503_1_3_20160315142357_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(IR_Family)_-_REMEDIATED.docx	IR Family Workbook- DY1, Q3 Remediation Document	03/15/2016 02:23 PM
	sak2047	Documentation/Certification	40_MDL0503_1_3_20160315142311_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AU_Family)_-_REMEDIATED.docx	AU Family Workbook- DY1, Q3 Remediation Document	03/15/2016 02:23 PM
	sak2047	Documentation/Certification	40_MDL0503_1_3_20160315142234_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Wo	AT Family Workbook- DY1, Q3 Remediation Document	03/15/2016 02:22 PM

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			rkbook_(AT_Family)_-_REMEDIATED.docx		
	cc599179	Documentation/Certification	40_MDL0503_1_3_20160129161036_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PS_Family).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (PS Family)	01/29/2016 04:10 PM
	cc599179	Documentation/Certification	40_MDL0503_1_3_20160129161000_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PE_Family).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (PE Family)	01/29/2016 04:10 PM
	cc599179	Documentation/Certification	40_MDL0503_1_3_20160129160922_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(IR_Family).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (IR Family)	01/29/2016 04:09 PM
	cc599179	Documentation/Certification	40_MDL0503_1_3_20160129160849_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AU_Family).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (AU Family)	01/29/2016 04:08 PM
	cc599179	Documentation/Certification	40_MDL0503_1_3_20160129160823_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AT_Family).docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (AT Family)	01/29/2016 04:08 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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).	The NYP/Q PPS is requesting an extension for this milestone to 2/15/16. The current state assessment has been completed but there were numerous issues scheduling the committees to vote on the approval of the document. This has now been scheduled for early February 2016 and the PPS will submit the completed document during the next quarterly report.
Develop an IT Change Management Strategy.	
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	
Develop a specific plan for engaging attributed members in Qualifying Entities	
Develop a data security and confidentiality plan.	The end date of task 3 was changed to 1/31/16 as the IT team is continuing to meet with partners to discuss and assess IT security.

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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.

Risk 1...Partners with varying IT infrastructures; some including paper based systems
Mitigation: Identify funding sources, in addition to DSRIP funding, for potential IT upgrades or new system implementation

Risk 2...Lack of approval for capital budget (CRFP) funding for PPS/partners
Mitigation: Implement a performance based system that will heavily incentivize those providers who require a capital outlay to meet requirements

Risk 3...Negative reaction of staff and / or practitioners due to system changes which will affect outcomes
Mitigation: Build a robust training program that aligns with Workforce, Cultural Competency, and Communication committees

Risk 4...High demand on the PPS RHIO partner which could impact timelines or outcomes
Mitigation: Appoint RHIO representative to the IT Committee, establish quarterly RHIO and partner meetings, and ensure transparency of all IT plans and timelines

Risk 5... Lack of partner understanding of change management needs/requirements of the PPS,etc.
Mitigation: Create communication strategies and IT governance to address change management needs

Risk 6... Compliance with data security policies
Mitigation: Create IT governance and appropriate audits to ensure compliance with data security policies

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.)

IT infrastructure is fundamental to support the workforce, funds flow initiatives, and performance management for all DSRIP workstreams in order to achieve milestones, project requirements, metric improvements, and reductions in hospital utilization to support. IT Systems and Processes is dependent upon effective training, implementation, and PMO provided through the Workforce plan, funding provided by the Finance plan, and alignment with the operational/clinical stakeholders within the Pop Health Management and Clinical Integration plans. The IT Systems & Processes plan is also dependent upon NY state created a sufficient patient consent process to allow for sufficient sharing of patient data. Finally, making sufficient investments in technology to support patient engagement and other program goals is dependent upon the PPS making the appropriate budget provided by meeting the overall DSRIP goals.

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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.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
IT Committee, Chair	Ken Ong, MD, NYP/Q CMIO	Manage IT Committee to ensure completion of Milestones Ensure transparency & collaboration among all partners Present monthly/quarter updates to the Executive Committee regarding IT developments
IT Committee, Vice Chair	Mark Greaker, NYP/QVP IT	Provide support to the Chair and Committee as a lead role Ensure progression of discussions & planning to ensure successful deliverable completion
IT Committee, Implementation Specialist	Marlon Hay, NYP/Q	Responsible for the successful implementation of IT projects for the PPS
IT Committee, Data Security Officer	Keith Weiner, NYP/Q	Responsible for the data security and HIPPA compliance for the PPS
IT Committee, PMO Data Analyst	Crystal Cheng, NYP/Q	Responsible for data management and performance reporting in the PMO
IT Committee, PMO Executive Director	Maria D'Urso, NYP/Q	Responsible for PMO oversight and coordination with the committee planning and implementation
IT Committee, Member	Mike Matteo, CenterLight Health System Vincent Villany, Parker Jewish Institute Derek Murray, Franklin Center for Rehabilitation and Nursing Bill Mora, Dr. Wm. Benenson Rehab. Pav. Darren French, MHPWQ Christopher Quinones, Brightpoint Health Caroline Keane, RN, NYHQ Kevin Kui, Queens Boulevard Extended Care Facility Michael Tretola, Silvercrest Chuck Jackson, Hospice of NY Cory Sherb, Selfhelp Community Services Jonah Cardillo, St. Mary's	Actively participate in committee discussions & decision making Become a liaison between the committee and partnering organizations or providers to provide updates regarding progress or policies
IT Committee, RHIO Representative	Tom Moore, Healthix	Provide information for PPS collaboration with leveraging the RHIO across DSRIP partners

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IPQR Module 5.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Home health agency representative	Project Committee Member (Long Term Care, Project 2..b.viii)	Liaison for Home Health Project, resource on telehealth & IT needs for home health care
Clinical Integration Leader	Clinical Integration Committee Member	Ensure IT strategy is aligned with clinical strategy, communicate plan with Clinical Integration Committee
Financial Sustainability Leader	Finance Committee Member	Budgets, align IT strategy with financial planning for PPS, communicate with finance committee
Workforce Strategy Leader	Workforce Committee Member	Assist with training strategy, communicating with workforce committee
Practitioner Engagement Leader	Practitioner Engagement Committee Member	Assist with clinical buy in for IT strategy and implementation process for practitioners
PPS Partners	All PPS Partners	Utilization of PPS wide IT plan, progress reporting, implementation
RHIO	Healthix	Provide IT Connectivity for PPS Partners
Clinical sub committees	9 project sub committees	Become a resource for clinical implementation planning & IT needs
External Stakeholders		
Bordering PPSs	PPS Leads	Partner with committee to ensure integration for providers crossing PPSs
Software Application Vendors	Infrastructure, Training	Provide software support & training specific to IT plan outlined

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

The PPS will implement standardized monthly reporting expectations for all workflows utilizing consistent tools and reports that outline expectations to the project, milestone, metric, and requirement level. Reporting will be a bottom-up model that feeds directly from patients, providers, and staff and will be leveraged as an accountability tool for the Executive Committee. A project management tool is under review and will be purchased based on finalized budget planning. Ongoing performance reporting will include:
-Documentation of process and workflow demonstrating implementation of electronic health record (EHR) across all partners
-Meaningful Use(MU) and PCMH level-3 tracking
-Documentation of patient engagement/communication system
-Evidence of use of telemedicine or other remote monitoring services
-Evidence of implementation of specific clinical workflows

IPQR Module 5.8 - IA Monitoring

Instructions :

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	In Progress	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…PMO IT staff to complete a Partner Performance Reporting Survey that outlines the current state of internal, state, and federal reporting expectations (monthly, quarterly, annually)	Completed	Step 1…PMO IT staff to complete a Partner Performance Reporting Survey that outlines the current state of internal, state, and federal reporting expectations (monthly, quarterly, annually)	07/01/2015	08/31/2015	07/01/2015	08/31/2015	09/30/2015	DY1 Q2	
Task Step 2…PMO IT & Data Analyst staff to align Project Metrics with Partner Performance Reporting Survey to ensure all metrics are reported	Completed	Step 2…PMO IT & Data Analyst staff to align Project Metrics with Partner Performance Reporting Survey to ensure all metrics are reported	08/01/2015	09/15/2015	08/01/2015	09/15/2015	09/30/2015	DY1 Q2	
Task Step 3…PMO IT & Data Analyst to create a Standard Reporting Package for monthly, quarterly, and annual reports that utilize Step 2 above	In Progress	Step 3…PMO IT & Data Analyst to create a Standard Reporting Package for monthly, quarterly, and annual reports that utilize Step 2 above	09/15/2015	11/01/2015	09/15/2015	03/15/2016	03/31/2016	DY1 Q4	
Task Step 4…PMO IT staff & IT Chair to establish PPS Performance Reporting Policy for reporting	In Progress	Step 4…PMO IT staff & IT Chair to establish PPS Performance Reporting Policy for reporting tools & communication channels	09/15/2015	11/01/2015	09/15/2015	02/15/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
tools & communication channels									
Task Step 5…PMO IT staff to create a Communication Channel Diagram & Communication Roll-Out Plan for the flow of Performance Reports to ensure a rapid cycle evaluation process throughout all levels of the PPS	Completed	Step 5…PMO IT staff to create a Communication Channel Diagram & Communication Roll-Out Plan for the flow of Performance Reports to ensure a rapid cycle evaluation process throughout all levels of the PPS	09/15/2015	11/01/2015	09/15/2015	11/01/2015	12/31/2015	DY1 Q3	
Task Step 6…PMO Executive to present communication roll-out plan to the IT Committee for review & recommendation to the Executive Committee	Completed	Step 6…PMO Executive to present communication roll-out plan to the IT Committee for review & recommendation to the Executive Committee	11/01/2015	11/30/2015	11/01/2015	11/30/2015	12/31/2015	DY1 Q3	
Task Step 7…IT Chair & PMO Executive to receive Executive Committee approval for the Performance Reporting Policy and Communication Channel Diagram & Roll-Out Plan	In Progress	Step 7…IT Chair & PMO Executive to receive Executive Committee approval for the Performance Reporting Policy and Communication Channel Diagram & Roll-Out Plan	12/01/2015	12/31/2015	12/01/2015	03/01/2016	03/31/2016	DY1 Q4	
Task Step 8…PMO Executive to assign Accountability Owners by Project and PPS Partner for all metrics, milestones, or project requirements	Not Started	Step 8…PMO Executive to assign Accountability Owners by Project and PPS Partner for all metrics, milestones, or project requirements	01/01/2016	01/31/2016	01/01/2016	01/31/2016	03/31/2016	DY1 Q4	
Task Step 9…PMO Executive to recruit PPS RN staff to do rapid cycle evaluation, reporting plans and findings to Clinical Integration Committee and appropriate sub-committees	Not Started	Step 9…PMO Executive to recruit PPS RN staff to do rapid cycle evaluation, reporting plans and findings to Clinical Integration Committee and appropriate sub-committees	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
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.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…IT Committee and PMO to Outline Reporting Package Benchmark Expectations by metric or project requirement with progressive expectations of minimum, median, and best practice	In Progress	Step 1…IT Committee and PMO to Outline Reporting Package Benchmark Expectations by metric or project requirement with progressive expectations of minimum, median, and best practice	08/01/2015	11/01/2015	08/01/2015	03/01/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 2…PMO IT & Data staff with input from clinical sub committee chairs to define Performance Metrics High/Low Expectations by metric, milestone, and/or requirement with a red/green/yellow light indicator to all a rapid risk approach to intervention	In Progress	Step 2…PMO IT & Data staff with input from clinical sub committee chairs to define Performance Metrics High/Low Expectations by metric, milestone, and/or requirement with a red/green/yellow light indicator to all a rapid risk approach to intervention	09/01/2015	11/15/2015	09/01/2015	03/01/2016	03/31/2016	DY1 Q4	
Task Step 3…IT Chair & PMO IT staff to construct a Quality Based Training Program, in collaboration with the Workforce training program and 1199TEF	In Progress	Step 3…IT Chair & PMO IT staff to construct a Quality Based Training Program, in collaboration with the Workforce training program and 1199TEF	09/15/2015	02/15/2016	09/15/2015	02/15/2016	03/31/2016	DY1 Q4	
Task Step 4…PMO IT staff to present training strategy to Workforce, Clinical sub committees and IT committee for revisions & approval	Not Started	Step 4…PMO IT staff to present training strategy to Workforce, Clinical sub committees and IT committee for revisions & approval	02/01/2016	02/29/2016	02/01/2016	02/29/2016	03/31/2016	DY1 Q4	
Task Step 5…IT Lead and PMO Executive to inform Executive Committee of final performance reporting training program	Not Started	Step 5…IT Lead and PMO Executive to inform Executive Committee of final performance reporting training program	03/01/2016	03/31/2016	03/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6…PMO to host Key Stakeholder Meetings, in partnership with the Clinical Integration Committee, quarterly to review performance reports, identify trends, plan for suggestions of action regarding low performers	Not Started	Step 6…PMO to host Key Stakeholder Meetings, in partnership with the Clinical Integration Committee, quarterly to review performance reports, identify trends, plan for suggestions of action regarding low performers	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	Task 3: Changed end date to 3/15/16 to align with the PPS recieving performance data from DOH and allow PPS to create processes based on what is received Task 4: Changed end date to 2/15/16 as the reporting policy is in the review process Task 7: Changed end date to 3/1/16 to accommodate time to have step 4 approved
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Tasks 1 & 2: Changed end dates to 3/15/16 to align with the PPS receiving performance data from DOH and allow PPS to create processes based on what is received

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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.

Risk 1…Inability to report metrics due to lack of system capabilities or lack of operational processes
Mitigation: Properly communicate metric expectations with timelines of reporting deliverables

Risk 2…Diminished practitioner engagement due to the busy schedules or buy-in to the DSRIP system
Mitigation: Distribute financial incentives based on performance and encourage organizational disbursement at the provider level

Risk 3...Inconsistency of data elements provided by PPS partners
Mitigation: Implementation of a Project Management software system that provides standardized definition and calculations

Risk 4... Reliance upon NY state to provide sufficient patient consent and data compliance laws to enable sufficient combination, viewing, and usage of patient information
Mitigation: Work closely with state

Risk 5... Combining data across different sources, including data provided by the DOH and data from the PPS, in order to collect and analyze for a single patient
Mitigation: Work closely with state to utilize and leverage existing technologies where applicable for elements like a Master Patient Index

Risk 6... RHIO's inability to connect PPS partners within DOH defined deadlines
Mitigation: Work closely with the RHIO as stakeholder to ensure that the RHIOs capabilities align with the IT and Performance Reporting Plan

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.)

Performance Reporting links directly to all DSRIP projects as metrics and project requirements will be reported using this workflow. Additional workflows that share interdependencies include: Finance, Practitioner Engagement, IT Systems & Processes, and Clinical Integration.

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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.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
IT Committee, Chair	Ken Ong, MD, NYP/Q, CMIO	Manage IT Committee to ensure completion of Milestones Ensure transparency & collaboration among all partners Present monthly/quarter updates to the Executive Committee regarding IT developments
IT Committee, Vice Chair	Mark Greaker, NYP/Q VP IT	Provide support to the Chair and Committee as a lead role Ensure progression of discussions & planning to ensure successful deliverable completion
IT Committee, Implementation Specialist	Marlon Hay, NYP/Q	Responsible for the successful implementation of IT projects for the PPS
IT Committee, Data Security Officer	Keith Weiner, NYP/Q	Responsible for the data security and HIPPA compliance for the PPS
IT Committee, PMO Data Analyst	Crystal Cheng, NYP/Q	Responsible for data management and performance reporting in the PMO
IT Committee, Member	Mike Matteo, CenterLight Health System Vincent Villany, Parker Jewish Institute Derek Murray, Franklin Center for Rehabilitation and Nursing Bill Mora, Dr. Wm. Benenson Rehab. Pav. Darren French, MHPWQ Christopher Quinones, Brightpoint Health Caroline Keane, RN, NYP/Q Kevin Kui, Queens Boulevard Extended Care Facility Michael Tretola, Silvercrest Chuck Jackson, Hospice of NY Cory Sherb, Selfhelp Community Services Jonah Cardillo, St, Mary's	Actively participate in committee discussions & decision making Become a liaison between the committee and partnering organizations or providers to provide updates regarding progress or policies
IT Committee,	Tom Moore, Healthix	Provide information for PPS collaboration with leveraging the RHIO across DSRIP partners

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IPQR Module 6.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Home health agency representative	Project Committee Member (Long Term Care, Project 2..b.viii)	Liaison for Home Health Project, resource on telehealth & IT needs for home health care
Clinical Integration Leader	Clinical Integration Committee Member	Ensure IT strategy is aligned with clinical strategy, communicate plan with Clinical Integration Committee
Financial Sustainability Leader	Finance Committee Member	Budgets, align IT strategy with financial planning for PPS, communicate with finance committee
Workforce Strategy Leader	Workforce Committee Member	Assist with training strategy, communicating with workforce committee
Practitioner Engagement Leader	Practitioner Engagement Committee Member	Assist with clinical buy in for IT strategy and implementation process for practitioners
PPS Partners	All PPS Partners	Utilization of PPS wide IT plan, progress reporting, implementation
RHIO	Healthix	Provide IT Connectivity for PPS Partners
Employees	Employees	Engage in training & implementation of performance reporting expectations
External Stakeholders		
CBO representative(s)	CBOs	Resource on human/social services, align IT needs (ie: food pantries, homeless shelters etc.)
1199TEF	Union	Resource on training & staffing expectations
PPS Partners	All PPS Partners	Utilization of PPS wide IT plan, progress reporting, implementation

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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.

The PPS will implement standardized monthly reporting expectations for all workflows utilizing consistent tools and reports that outline expectations to the project, milestone, metric, and requirement level. Reporting will be a bottom-up model that feeds directly from patients, providers, and staff and will be leveraged as an accountability tool for the Executive Committee. Additionally, analytics tools will be used to develop reports that monitor process and outcome measures with data from EHRs, Allscripts Care Director (care management platform), the Healthix RHIO and implementation reports. The NYHQ PPS PMO will review analytics reports and performance measures on a bimonthly basis to ensure that targets are on track to be met and reported on.

Given the diverse array of CBOs and provider organizations involved in this PPS, the PPS will conduct an initial data governance assessment as well as develop a data governance council to set data standards, assess ongoing data quality, and recommend actions to PPS leadership that will improve the quality of the data. A project management tool is under review and will be purchased based on finalized budget planning.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

The PPS will implement standardized monthly reporting expectations for all workflows utilizing consistent tools and reports that outline expectations to the project, milestone, metric, and requirement level. Reporting will be a bottom-up model that feeds directly from patients, providers, and staff and will be leveraged as an accountability tool for the Executive Committee. A project management tool is under review and will be purchased based on finalized budget planning.

IPQR Module 6.9 - IA Monitoring

Instructions :

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	In Progress	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	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…PMO Executive to formalize Practitioner Engagement sub-committee	Completed	Step 1…PMO Executive to formalize Practitioner Engagement sub-committee	07/01/2015	09/01/2015	07/01/2015	09/01/2015	09/30/2015	DY1 Q2	
Task Step 2…PMO Data Analyst to compile detailed Practitioner Matrix that outlines current clinical state, project commitments, risks, and targeted requirements	Completed	Step 2…PMO Data Analyst to compile detailed Practitioner Matrix that outlines current clinical state, project commitments, risks, and targeted requirements	09/01/2015	10/31/2015	09/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task Step 3…PMO Executive to engage associations or medical societies relevant to our practitioner types in the Practitioner Engagement Committee and by presenting at association meetings	In Progress	Step 3…PMO Executive to engage associations or medical societies relevant to our practitioner types in the Practitioner Engagement Committee and by presenting at association meetings	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4…Clinical Integration & Quality Committee Chair to complete a Practitioner Focus Group inclusive of all types and geographical locations	Not Started	Step 4…Clinical Integration & Quality Committee Chair to complete a Practitioner Focus Group inclusive of all types and geographical locations to identify communication gaps	09/01/2015	12/31/2015	01/01/2016	03/01/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
to identify communication gaps									
Task Step 5…PMO to create bi-annual Learning Collaborative with guest speakers and panel discussions to focus to lessons learned and best practice standards	In Progress	Step 5…PMO to create bi-annual Learning Collaborative with guest speakers and panel discussions to focus to lessons learned and best practice standards	09/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6…PMO & Communications team to develop a communication and engagement plan and present to the Communications committee for review	Completed	Step 6…PMO & Communications team to develop a communication and engagement plan and present to the Communications committee for review	09/01/2015	12/01/2015	09/01/2015	12/01/2015	12/31/2015	DY1 Q3	
Task Step 7…PMO & Communications Chair to present plan to the Executive Committee for approval	In Progress	Step 7…PMO & Communications Chair to present plan to the Executive Committee for approval	12/01/2015	02/01/2016	12/01/2015	02/01/2016	03/31/2016	DY1 Q4	
Task Step 8…PMO & Communications Chair to present plan to PAC and PPS partners	Not Started	Step 8…PMO & Communications Chair to present plan to PAC and PPS partners	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	In Progress	Practitioner training / education plan.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…PMO & Clinical Chairs to align strategies with associations to provide DSRIP 101/prevention goals/performance goals/case and/or care management education sessions and/or updates to practitioners in previously scheduled meetings	In Progress	Step 1…PMO & Clinical Chairs to align strategies with associations to provide DSRIP 101/prevention goals/performance goals/case and/or care management education sessions and/or updates to practitioners in previously scheduled meetings	09/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2…Communications team & PMO staff to establish a web-based communication hub for practitioners to obtain relevant information to projects, requirements, best practices, and upcoming deadlines	In Progress	Step 2…Communications team & PMO staff to establish a web-based communication hub for practitioners to obtain relevant information to projects, requirements, best practices, and upcoming deadlines	12/01/2015	03/01/2016	12/01/2015	03/01/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task Step 3…PMO to partner with the Workforce & Communication Committee to integrate practitioner/staff training & education plan into overall training & education programs outlined in this milestone. Ensure training program is ongoing and incorporated into annual training (or appropriate timeframe based on topic) for providers & staff	In Progress	Step 3…PMO to partner with the Workforce & Communication Committee to integrate practitioner/staff training & education plan into overall training & education programs outlined in this milestone. Ensure training program is ongoing and incorporated into annual training (or appropriate timeframe based on topic) for providers & staff	12/01/2015	02/28/2016	12/01/2015	02/28/2016	03/31/2016	DY1 Q4	
Task Step 4…Lead Hospital (NYHQ) to explore options of providing CME credits for practitioner involvement & education	In Progress	Step 4…Lead Hospital (NYHQ) to explore options of providing CME credits for practitioner involvement & education	12/01/2015	02/28/2016	12/01/2015	02/28/2016	03/31/2016	DY1 Q4	
Task Step 5…PMO Executive to submit to Workforce & Executive Committee for approval	Not Started	Step 5…PMO Executive to submit to Workforce & Executive Committee for approval	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6… PMO to create a forum for providers & staff to provide feedback on training sessions and suggestions for new training/education sessions to be hosted by PPS	In Progress	Step 6… PMO to create a forum for providers & staff to provide feedback on training sessions and suggestions for new training/education sessions to be hosted by PPS	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	Task 4 moved to 7/1/16 to accommodate planning needs for PPS to organize focus groups Task 5 moved to 8/1/16 to ensure no duplication with PCG learning collaborative and that implementation roll out has begun to allow for productive and applicable learning collaboratives
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Task 1 end date changed to 3/1/16 to allow PPS to continue to hold these sessions at staff meetings

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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.

Risk 1…Lack of protected administrative time for practitioners
Mitigation: Secure incentive funding for non-clinical items such as training and committee participation

Risk 2…Mission Collision - Practitioner vision does not align with DSRIP "triple-aim" approach of healthcare improvements
Mitigation: Partner with associations and medical societies to integrate current best practices into their culture to align with DSRIP vision

Risk 3...Incremental practitioner PPS network resignation due to lack of PPS level results and funding
Mitigation: Build a transparent reporting and communication process and engage practitioners on all committees to allow for input and influence of processes

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.)

Practitioner Engagement links directly to Workforce, IT Systems & Processes, and Clinical Integration with interdependencies of practitioner compliance, engagement, and ability to transition into new processes. The engagement of the NYHQ PPS practitioners is a critical element of all workstreams to ensure the success of domain metrics. Project and function implementation will be development with the engagement of all practitioners to ensure tailored programs to our patient and practitioner base.

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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.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Practitioner Engagement Sub-Committee, Chair	Marilyn Castaldi, Interim Vice President, Public Affairs & Marketing, NYP/Q	Align communication strategy for PPS wide communication & communication specific to practitioner types
Practitioner Engagement Sub-Committee, PPS Executive Leadership Member	Maria D'Urso, NYP/Q	PMO liaison
Practitioner Engagement Sub-Committee, LTC Sub-Committee Member	Michael Tretola, SVP & Administrator for Silvercrest Nursing & Rehabilitation	Assist with engagement strategy to utilize best practices for practitioner engagement
Practitioner Engagement Sub-Committee, PPS PMO Member	TBD, PPS PMO Staff Member	DSRIP 101 creation & presentation
Practitioner Engagement Sub-Committee, Clinical Integration Committee Member	Anthony Somogyi, MD, NYP/Q	Provide leadership and strategic direction to the committee ensuring a focus to the DSRIP mission and deliverables
Practitioner Engagement Sub-Committee, IT Committee Member	Mark Greaker, NYP/Q	Active participant in the Clinical Integration Committee Provide updates & feedback pertaining to IT & Reporting
Practitioner Engagement Sub-Committee, Asthma Sub-Committee Member	Hadi Jabbar, MD, NYP/Q	Active participant in the Clinical Integration Committee Provide updates & feedback specific to Asthma initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the Committee
Practitioner Engagement Sub-Committee, HIV Sub-Committee Member	David Rubin, MD, NYP/Q	Active participant in the Executive Committee Provide updates & feedback specific to HIV initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the Committee
Practitioner Engagement Sub-Committee, LTC Sub-Committee Member	Caroline Keane, NYP/Q	Active participant in the Practitioner Engagement sub-committee Provide updates & feedback specific to Long Term care initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		Committee

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IPQR Module 7.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Clinical Integration Committee	Anthony Somogyi, MD, NYP/Q	Resource for practitioner/clinical perspective
Clinical Sub Committees	David Rubin MD, NYP/Q Haddi Jabbar, MD, NYP/Q Caroline Keane, NYP/Q Maureen Buglino, NYP/Q Maria D'Urso, NYP/Q	Resource for practitioner/clinical perspective
Workforce Committee	Loraine Orlando, NYP/Q	Align training strategy with workforce training, deliverables & budget
Communications Committee	Willa Brody, NYP	Align communication strategy
Finance Committee	Frank Hagan NYP/Q	Align training strategy with PPS budget & funds flow
PPS Partners	Providers	Engagement & feedback on PPS strategy
External Stakeholders		
Medical Associations	Examples: Medical Society of Queens County Medical Society of the State of New York American Association of Physicians of Indian Origins Queens The Association of Chinese Physicians American College of Physicians	Provide a venue for provider engagement with a focus to quality based improvements & collaboration
Bordering PPSs	Bordering PPSs	Cross PPS collaboration to ensure practitioner engagement & no saturation
Practitioner Training Programs	Examples: GME, EMS	Training

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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.

The PPS will implement standardized monthly reporting expectations for all workflows utilizing consistent tools and reports that outline expectations to the project, milestone, metric, and requirement level. Reporting will be a bottom-up model that feeds directly from patients, providers, and staff and will be leveraged as an accountability tool for the Executive Committee. A project management tool is under review and will be purchased based on finalized budget planning.

IPQR Module 7.8 - Progress Reporting

Instructions :

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

The PPS will implement standardized monthly reporting expectations for all workflows utilizing consistent tools and reports that outline expectations to the project, milestone, metric, and requirement level. Reporting will be a bottom-up model that feeds directly from patients, providers, and staff and will be leveraged as an accountability tool for the Executive Committee. A project management tool is under review and will be purchased based on finalized budget planning.

IPQR Module 7.9 - IA Monitoring

Instructions :

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	In Progress	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.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1…PMO IT staff to assess current Population Health IT by determining level of tools currently being used throughout the PPS coordinated with IT Systems and Processes workstream plan and formulating IT Assessment and Issue Resolution Planning across PPS	Completed	Step 1…PMO IT staff to assess current Population Health IT by determining level of tools currently being used throughout the PPS coordinated with IT Systems and Processes workstream plan and formulating IT Assessment and Issue Resolution Planning across PPS	07/01/2015	11/01/2015	07/01/2015	11/01/2015	12/31/2015	DY1 Q3	
Task Step 2..Based on results on NYHQ PPS assessment, PMO IT staff will utilize IT roadmap for population health management (refer to IT Systems and Processes workstream plan, Milestone 1 Step 4: Roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements)	Not Started	Step 2..Based on results on NYHQ PPS assessment, PMO IT staff will utilize IT roadmap for population health management (refer to IT Systems and Processes workstream plan, Milestone 1 Step 4: Roadmap of tactical and strategic recommendations with high-level budget estimates and resource requirements)	11/01/2015	02/01/2016	11/01/2015	02/01/2016	03/31/2016	DY1 Q4	
Task Step 3.. Clinical Integration Committee will align project planning and implementation with population health management processes and	Not Started	Step 3.. Clinical Integration Committee will align project planning and implementation with population health management processes and tools outlined by Clinical sub	12/01/2015	03/01/2016	12/01/2015	03/01/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
tools outlined by Clinical sub committee planning & project implementation		committee planning & project implementation							
Task Step 4…PMO IT staff, PMO Executive, and IT Chair to define the target population and population health management plan for identifying and engaging patients in the appropriate level of care management according to their needs, specifically addressing the cultural and health disparities	Not Started	Step 4…PMO IT staff, PMO Executive, and IT Chair to define the target population and population health management plan for identifying and engaging patients in the appropriate level of care management according to their needs, specifically addressing the cultural and health disparities	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4	
Task Step 5…PMO IT staff to create a population health management roadmap	Not Started	Step 5…PMO IT staff to create a population health management roadmap	02/01/2016	05/01/2016	02/01/2016	05/01/2016	06/30/2016	DY2 Q1	
Task Step 6…IT Chair to submit roadmap to Clinical Integration Community & Executive Committee for review & approval	Not Started	Step 6…IT Chair to submit roadmap to Clinical Integration Community & Executive Committee for review & approval	05/01/2016	06/30/2016	05/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	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.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1...Create bed management plan that includes impact on workforce, financial funds flow, governance as pre-established in workstream flows. Bed management plan will include recommendations on utilization plan for beds based on the transition to VBP and increased outpatient/preventative services. (*Note - PPS CNA reflects no excess bed capacity within service area; therefore, no bed reductions will be proposed and the action item is a bed management plan versus a reduction plan)	Not Started	Step 1...Create bed management plan that includes impact on workforce, financial funds flow, governance as pre-established in workstream flows. Bed management plan will include recommendations on utilization plan for beds based on the transition to VBP and increased outpatient/preventative services. (*Note - PPS CNA reflects no excess bed capacity within service area; therefore, no bed reductions will be proposed and the action item is a bed management plan versus a reduction plan)	01/01/2016	11/01/2016	01/01/2016	11/01/2016	12/31/2016	DY2 Q3	
Task Step 2...Submit bed management plan to Clinical Integration Committee & Executive Committee	Not Started	Step 2...Submit bed management plan to Clinical Integration Committee & Executive Committee for review & approval	11/01/2016	01/01/2017	11/01/2016	01/01/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
for review & approval									
Task Step 3…Present bed management plan to PPS partners and PAC	Not Started	Step 3…Present bed management plan to PPS partners and PAC	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	
Finalize PPS-wide bed reduction plan.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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.

Risk 1...According to the CNA submitted with the application, both primary and secondary data collection indicates that the service area is not over-bedded from an acute care perspective. The 2,369 service are beds is equal to 1.49 beds per 1,000 persons, which is lower than the state average of 3.0 beds per 1,000 and lower than the national average of 2.6 beds per 1,000.
Mitigation...PPS is not suggesting growth or bed reduction, which can be conceived as a risk to the implementation plan of the PPS. Mitigation strategy for bed reduction operational plans would be to incorporate data from the CNA, while recognizing that a low inpatient bed rate per 1,000 may be appropriate. NYHQs focus will shift toward outpatient care and coordination of care

Risk 2...Interoperability tools that are required for Population Health IT (PHIT) systems and the implementation speed for these tools throughout the PPS. These tools are required to fulfill communication, patient care, patient tracking, and outcomes monitoring needs across the continuum. Because PHIT is foundational to the nine NYHQ DSRIP project requirements, delayed PHIT implementation steps delay other project steps and put the PPS at risk of not meeting project speed and scale requirements.
Mitigation...Tracking and championing implementation of PHIT interoperability and strategizing for other methods, such as mixed documentation using alternate methods where EHRs and PHIT tool functionality are not yet ready.

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.)

The Population Health Management implementation plan is linked with all functional workstreams, particularly the IT Systems, Clinical Integration, Performance Reporting and funds flow workstream. Population health management is integral to projects requiring care management and care transitions since all of the DSRIP projects contain various types of links to Population Health Management tools and PHIT systems.

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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.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Clinical Integration Committee Chair	Anthony Somogyi, MD, NYP/Q	Provide leadership and strategic direction to the committee ensuring a focus to the DSRIP mission and deliverables
Clinical Integration Committee Vice Chair	Maria D'Urso, RN, NYP/Q	Partner with the Chair & Members to accomplish deliverables outlined in the Clinical Integration Committee Charter or DSRIP deliverable schedule Perform Chair responsibilities when Chair is not present
Clinical Integration Committee Member, IT Representative	Mark Greaker, NYP/Q	Active participant in the Clinical Integration Committee Provide updates & feedback pertaining to IT & Reporting
Clinical Integration Committee Member, PMO Operations	TBD, NYP/Q	Provide operation support to committee Become a liaison between the PMO and the Committee
Clinical Integration Committee Member, Asthma Project	Hadi Jabbar, MD, NYP/Q	Active participant in the Clinical Integration Committee Provide updates & feedback specific to Asthma initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the Committee
Clinical Integration Committee Member, HIV Project	David Rubin, MD, NYP/Q	Active participant in the Committee Provide updates & feedback specific to HIV initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the Committee
Clinical Integration Committee Member, LTC Projects	Caroline Keane, NYP/Q	Active participant in the Clinical Integration Committee Provide updates & feedback specific to Long Term care initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		Committee
Clinical Integration Committee Member, PMO Data Analyst	Crystal Cheng, NYP/Q	Provide data and analytic support

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IPQR Module 8.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Mary Godfrey, RN	VP, Patient Processing & Capacity Management	Resource for bed management planning
Caroline Keane, RN	VP, Care Management / LTC Project Committee Chair	Integrate bed management plan into the LTC committee planning for care transitions
Clinical Integration Committee	Committee Member	Resource for clinical perspective on population health management
IT Committee	Committee Member	Align population health management IT with IT committee strategy
PPS Partners	All PPS Partners	Resource for information on attributed population, participate in population health management strategy
RN Staff Representative	TBD	Resource for information on attributed population, participate in population health management strategy
External Stakeholders		
PPS Partners	All PPS Partners	Resource for information on attributed population, participate in population health management strategy
Population Health Management Vendors	Vendors	Provide resource & training for population health management tools

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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.

The optimal goal for Population Health Management IT tools is to be completely interoperable between all participating members of the PPS to some degree. The Population Health Management tool selected by the PPS can:
1) provide analytic capabilities to fulfill DSRIP reporting requirements and produce operational monitoring reports
2) promote efficient and effective patient outreach
3) ensure patient preventive care standards are identified and tracked
4) support disease management guideline adherence
5) communicate across the continuum. EHR linkages must be able to share clinical data and track patient movement and utilization across PPS health providers and organizations. Milestones and metrics will help to drive expectations.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

The success of this workstream will be measured by the timely completion of the milestones, the interoperability of the EMR and the improvement of patient focused quality outcomes utilizing tools managed by the Project Management Office and Clinical Integration Committee(s). Data will be tracked and reported with dashboards including, but not limited to patient engagement goals and percentages, HEDIS metrics, tracking and validating progress both within the NYHQ PPS attributed population, and also with the collaborated PPS programs within the metropolitan New York City initiatives and any established shared services.

IPQR Module 8.9 - IA Monitoring

Instructions :

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	In Progress	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	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…PMO staff will utilize Practitioner Matrix created in the Practitioner Engagement workflow to identify provider requirements and data points in order to clearly establish a clinical baseline of processes	Completed	Step 1…PMO staff will utilize Practitioner Matrix created in the Practitioner Engagement workflow to identify provider requirements and data points in order to clearly establish a clinical baseline of processes	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2…Clinical sub committee leads and PMO staff will draft a clinical integration needs assessment considering people, process & technology based on project and function	In Progress	Step 2…Clinical sub committee leads and PMO staff will draft a clinical integration needs assessment considering people, process & technology based on project and function	10/01/2015	02/01/2016	10/01/2015	02/01/2016	03/31/2016	DY1 Q4	
Task Step 3…PMO Executive to present clinical integration needs assessment to the Clinical Integration Committee and Executive Committee with recommendations and timelines	Not Started	Step 3…PMO Executive to present clinical integration needs assessment to the Clinical Integration Committee and Executive Committee with recommendations and timelines	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1…PMO Clinical staff will utilize the Clinical Integration Needs Assessment to establish an integration strategy that outlines current state, desired state, action items, and timelines	In Progress	Step 1…PMO Clinical staff will utilize the Clinical Integration Needs Assessment to establish an integration strategy that outlines current state, desired state, action items, and timelines	07/01/2015	11/01/2015	07/01/2015	05/01/2016	06/30/2016	DY2 Q1	
Task Step 2…PMO IT staff & clinical staff will utilize IT assessments to determine electronic clinical integration capabilities and needs	In Progress	Step 2…PMO IT staff & clinical staff will utilize IT assessments to determine electronic clinical integration capabilities and needs	09/01/2015	12/31/2015	09/01/2015	05/01/2016	06/30/2016	DY2 Q1	
Task Step 3…PMO clinical staff & clinical sub committee chairs will create Clinical Integration Strategy, including training & communication plans for providers & staff	Not Started	Step 3…PMO clinical staff & clinical sub committee chairs will create Clinical Integration Strategy, including training & communication plans for providers & staff	10/01/2015	02/01/2016	01/01/2016	02/01/2016	03/31/2016	DY1 Q4	
Task Step 4…PMO clinical staff & Executive lead will present Clinical Integration Strategy to the Clinical Integration Committee, Workforce Committee and Executive Committee for feedback and approval of implementation	Not Started	Step 4…PMO clinical staff & Executive lead will present Clinical Integration Strategy to the Clinical Integration Committee, Workforce Committee and Executive Committee for feedback and approval of implementation	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1	
Task Step 5…PMO clinical staff & Executive lead will utilize the approved Clinical Integration Strategy and project specific strategies to create an	Not Started	Step 5…PMO clinical staff & Executive lead will utilize the approved Clinical Integration Strategy and project specific strategies to create an overarching Care Transition Strategy focused to people, process, technology, and training specific	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
overarching Care Transition Strategy focused to people, process, technology, and training specific to project and patient need		to project and patient need							
Task Step 6…PMO Clinical staff will present Care Transition Strategy to Clinical Integration Committee, Workforce Committee and Executive Committee for review & approval	Not Started	Step 6…PMO Clinical staff will present Care Transition Strategy to Clinical Integration Committee, Workforce Committee and Executive Committee for review & approval	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	
Develop a Clinical Integration strategy.	Task 1 & 2 end date moved to 5/1/16 to align with the completion of milestone 1 and kick off of milestone 2

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	

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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.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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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.

Risk 1…Interoperability of multiple IT systems
Mitigation: Engage vendors and utilize relationships with RHIO to bridge the gap of data systems

Risk 2…Alignment of timing expectations of DSRIP deliverables with the timing of IT infrastructures to ensure success
Mitigation: Establish clear expectations at all levels with timing expectations and identify risks quickly through committees or learning collaborative

Risk 3...Inability to meet workforce demands due to recruitment or retraining demands
Mitigation: Partner with Workforce Committee to align strategies, identify risks, and plan for delays due to workforce effects

Risk 4...Readiness of PPS clinical platform to make rapid dynamic changes
Mitigation: Establish a Rapid Cycle Evaluation Unit, within the PMO, to identify and address issues related to implementation & change management

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.)

Interdependencies of this workflow include:

Performance Reporting - The implementation of projects and functions will be monitored closely with the performance reporting workflow and will identify trends or risks associated with clinical integration.

Workforce - The impact of recruitment, retraining, redeployment, and reduction in staff will play an important role in clinical integration as ensuring adequate workforce will define the success of meeting requirements and domain metrics.

Practitioner Engagement - Proper engagement of practitioners and partners will ensure a smooth implementation of projects as they are the individuals performing majority of the work to meet the outcome expectations.

Population Health Management - Tools and strategies utilized in this workflow will impact the integration and strategy of clinical developments as the PPS manages large volumes of patients with a focus to evidence based medicine & quality outcomes.

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Cultural Competency & Health Literacy - This workflow will directly relate to clinical integration as the PPS must ensure that medical processes and people align with the cultural diversity and needs of the community we serve while implementing clinical programs.

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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.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Clinical Integration Committee Chair	Anthony Somogyi, MD, NYP/Q	Provide leadership and strategic direction to the committee ensuring a focus to the DSRIP mission and deliverables
Clinical Integration Committee Vice Chair	Maria D'Urso, NYP/Q	Partner with the Chair & Members to accomplish deliverables outlined in the Clinical Integration Committee Charter or DSRIP deliverable schedule Perform Chair responsibilities when Chair is not present
Clinical Integration Committee Member, IT Representative	Mark Greaker, NYP/Q	Active participant in the Clinical Integration Committee Provide updates & feedback pertaining to IT & Reporting
Clinical Integration Committee Member, PMO Operations	TBD, NYP/Q	Active participant in the Executive Committee Provide operation support to committee Become a liaison between the PMO and the Committee
Clinical Integration Committee Member, Asthma Project	Hadi Jabbar, MD, NYP/Q	Active participant in the Clinical Integration Committee Provide updates & feedback specific to Asthma initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the Committee
Clinical Integration Committee Member, HIV Project	David Rubin, MD, NYP/Q	Active participant in the Executive Committee Provide updates & feedback specific to HIV initiatives, market dynamics, or community happenings Become a liaison between the partner & provider community & the Committee
Clinical Integration Committee Member, LTC Projects	Caroline Keane, NYP/Q	Active participant in the Clinical Integration Committee Provide updates & feedback specific to Long Term care initiatives,

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		market dynamics, or community happenings Become a liaison between the partner & provider community & the Committee
Clinical Integration Committee Member, RHIO Representative	Tom Moore, Healthix	Provide information for PPS collaboration with leveraging the RHIO across DSRIP partners

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IPQR Module 9.6 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Karen Nefores	VP Quality, NYP/Q	Resource to the committee for clinical quality improvements and leveraging best practices in the PPS
Frank Hagan	VP Finance, NYP/Q	Finance Committee Liaison
Caroline Keane	Case Management, Social Work, NYP/Q	Long Term Care Committee Liaison
Mary Godfrey	VP, Patient Processing & Capacity Management NYP/Q	Resource for bed management in the NYP/Q PPS
Healthix Representative	RHIO Representative	Provide feedback on electronic integration plan and training for PPS partners
Practitioners	Clinical providers	Provide feedback & recommendations for integration
External Stakeholders		
Community Based Organizations Examples of CBOs to be engaged include: the Asthma Coalition of Queens, Catholic Charities, Self-help Community Services, Silvercrest Housing	PPS Partner CBOs	Advise on community needs and training
Bordering PPSs	Cross PPS collaboration	Engage in collaborative meetings to allow for cross PPS transparency and synergy

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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.

The development of a shared IT infrastructure is the core principal of Clinical Integration as the primary DSRIP goal of IT is to connect systems in order to integrate clinically and technically in order to meet expectations. NYHQ partners IT capabilities vary and the IT Systems & Process workflow will focus to identifying current state & strategy for ensuring connectivity and inter-operability to manage clinical integration & successful outcomes of domain metrics & project requirements.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

The PPS will implement standardized monthly reporting expectations for all workflows utilizing consistent tools and reports that outline expectations to the project, milestone, metric, and requirement level. Reporting will be a bottom-up model that feeds directly from patients, providers, and staff and will be leveraged as an accountability tool for the Executive Committee. A project management tool is under review and will be purchased based on finalized budget planning.

IPQR Module 9.9 - IA Monitoring:

Instructions :

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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.

The New York Hospital Queens PPS approach to implementation of the DSRIP projects includes an organizational structure that will oversee the DSRIP initiatives. The DSRIP project management office (PMO) convened for project planning and implementation will follow a process which includes: identifying, selecting and engaging current and potential future PPS project partners, defining roles and responsibilities, applying DSRIP project requirements, milestones and metrics to implementation templates, using evidence-based clinical, organizational and population health practices throughout the projects while coordinating with other projects. The clarity of the PPS partners' roles and responsibilities provided by the Collaborative Contracting model, governance structure combined with the resources of NYHQ, will enable the PPS participants to concentrate on the strategies necessary for successful DSRIP projects, including oversight, implementation, performance reporting, and accountability for patient and population outcomes.

The PMO will align key approaches for the DSRIP projects including maintaining the project management system, ensuring that DSRIP projects are coordinated with each other, particularly those projects that intersect with each other such as those related to SNFs, identifying and facilitating collaborative alignment, uses feedback systems to monitor effectiveness and activate rapid response process; and involving PPS leaders for risk mitigation if necessary.

A key responsibility of the PMO is to ensure that a predominant focus of successful DSRIP project plan implementation is the connectivity component of the IT and Clinical Integration structures. The PMO is responsible for linking project teams with the IT work stream (refer to Part 1 IT Systems and Processes work streams) provide user input, establish timelines, and to facilitate transitional manual processes until electronic systems are functional. This is of primary focus with NYHQ PPS since it has been identified that they are varying levels of operability within the existing PPS members. This focus will only help to successfully implement the nine projects that have been identified.

IPQR Module 10.2 - Major dependencies between work streams and coordination of projects

Instructions :

Please describe how your approach will handle interdependencies between complementary projects, as well as between projects and cross-cutting PPS initiatives - for example, an IT infrastructure upgrade, or the establishment of data sharing protocols.

The population health emphasis of the DSRIP projects helps to focus teams on continuum of care processes and coordination, rather than a silo of activities associated with improvements at a single level or of an isolated process. The PMO will be the population health advocate for the teams to ensure they are continually looking at the whole patient.

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The transitions of care projects contain overlapping and synergistic requirements; the PPS is using a bundle approach for Projects 2.b.v., 2.b.vii, 2.b.viii, and 3.g.ii. Project teams are working together to coordinate and execute the overall vision of transitions of care and care coordination for the NYHQ PPS with a predominate focus on the patient population utilizing area SNFs. Improvement meetings will alternate between the individual project teams working on their action plans and individual teams coming together for process coordination and alignment. The PMO will monitor progress and evaluate effectiveness of interventions. The benefit to this bundling approach will be that the key stakeholders and the front end health care providers will benefit from intertwined improvements that directly impact patient outcomes and coordination of care.

Projects 3.b.i and 3.d.ii will address cross-cutting PPS initiatives in partnering with geographic resources that support the community as a whole, moving outside the normal boundaries of patient engagement. Workflow teams focusing on HIV care have already begun to address the needs of early access and patient retention in this area, with anticipated collaboration throughout the project. The asthma home-based self-management project will expand on recognized best practice initiatives that have been in existence with subject matter experts in this field, who will drive the project to achieve key milestones and metrics. The NYHQ PPS will integrate the support and collaboration from these community based organizations to leverage toward improved population health outcomes.

The Patient Centered Medical Home provides the platform for implementing the role of primary care providers in the projects, while allowing for integration of behavioral health services. The NYHQ PPS will leverage the overlapping requirements of the DSRIP projects and the NCQA PCMH requirements. The functional areas of Cultural Competency / Health Literacy, IT systems, Population Management, and Workforce all have linkages to the projects and are being accounted for in project planning.

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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.

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Long Term Care Committee Chair (2.b.v, 2.b.vii, 2.b.viii, 3.g.ii)	Caroline Keane, NYP/Q	Liaison to committee, leveraging best practices, communication to Clinical Integration Committee
High Risk Population Committee Chair- Asthma (3.d.ii)	Hadi Jabbar, MD- NYP/Q	Liaison to committee, leveraging best practices, communication to Clinical Integration Committee
High Risk Population Committee Chair- HIV (4.c.ii)	David Rubin, MD- NYP/Q	Liaison to committee, leveraging best practices, communication to Clinical Integration Committee
Behavioral Health (3.a.i) & Primary Care Committee Chair	Maureen Buglino, NYP/Q	Liaison to committee, leveraging best practices, communication to Clinical Integration Committee
Cardiovascular Committee (2.a.ii, 3.b.i) Chair	Anthony Somogyi, MD- NYP/Q	Liaison to committee, leveraging best practices, communication to Clinical Integration Committee

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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.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
PPS Clinical Committees	Committee Members	Create the implementation plan & clinical planning for PPS selected projects
External Stakeholders		
PPS Partners	All PPS Partners	Completion of metrics & project requirements in each project
NYS	examples: DOH, OASAS	Utilize resources and partner with agencies when appropriate to implement and accomplish projects
Bordering PPSs	Bordering PPSs	Partner on overlapping projects to ensure that there is not a duplication of resources and streamline work for participating practitioners

IPQR Module 10.5 - IT Requirements

Instructions :

Information technology will play a crucial role in the development of an effective, integrated performing provider system. It is likely that most projects will require some level of supporting IT infrastructure. Please describe the key elements of IT infrastructure development that will play a role in multiple projects.

The NYHQ PPS IT infrastructure role will drive successful realization of project requirements and goals. Project plans and implementation will need to be orchestrated with IT integration and upgrades to ensure interoperability and data sharing. Implementation plans will address current state analysis which shows a wide variety of levels of interoperability at the beginning of the DSRIP projects. The PMO will coordinate the speed and timing of the projects so that they coincide with the different health IT platforms. Workgroups and transformation processes will be developed and augmented along the delivery pathway.

A component of the IT integrated performing system requirement will be instituting population health management technology through the PPS. This, in coordination with meeting meaningful use and PCMH Level 3 standards for designated providers will be key to successful implementation of the DSRIP projects. In order to accomplish this, the following steps will need to be incorporated into the general implementation plans:

1) Establish the processes and structures to implement the Data-Sharing and Confidentiality requirements as defined in the DSRIP Organization Plan
2) Incorporate development/acquisition of capabilities and infrastructure into the Population Health IT work plan.
3) Ensure the Population Health IT work plan prioritizes the steps/actions, hardware, and other resources required to achieve EMR access
4) Align IT and clinical workflows across project plans
5) When, EHR/RHIO functionality is not compatible, identify alternate methods of generating work product until it interoperable
6) Implement essential clinical processes using manual documentation and communication as indicated and transition to electronic as it becomes available

IPQR Module 10.6 - Performance Monitoring

Instructions :

Please explain how your DSRIP projects will fit into your development of a quality performance reporting system and culture.

The DSRIP projects as the basis for the progress and performance reporting that is necessary to demonstrate effectiveness of the program. Provider, clinical quality outcomes, patient engagement and population health transformation will be demonstrated through performance monitoring. Incentive structures and flow of funds will also revolve around performance monitoring. A DSRIP Data and Performance workflow team is a component of the PMO and will be used to provide data analysis, process improvement and utilization metrics, and dashboard development support to the DSRIP project teams. Areas of focus include the following four subsets:

Metrics in collaboration with Population Health Management and project teams to establish reporting tools to gather data, dashboards and other reports. Analysis; Work with data to determine project and software needs to advance project planning. Process improvements; based on metrics

will be used by the NYHQ PPS to measure, compare and advance project requirements and milestones, and education on the metrics and educate on tools, data analysis and improvement methods to achieve performance reports.

The NYHQ PPS IT and Data Committee will support performance monitoring with the mentioned metrics, milestones, and reporting required ensuring clinical integration. It will work to achieve interoperability of partner platforms and RHIO s to share and utilize outcome data in real time. It will standardize data definitions; prioritize allocation of IT resources and joint IT investments; and recommend the selection of population health management applications and IT approaches. This committee will also oversee IT and data security and compliance, data storage and usage, and data services.

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IPQR Module 10.7 - Community Engagement

Instructions :

Please describe your PPS's planned approach for driving community involvement in the DSRIP projects, how you will contract with CBOs for these projects, how community engagement will contribute to the success of the projects, and any risks associated with this.

The NYHQ plan for community engagement recognizes that engagement occurs at multiple levels including PPS, organizational, programmatic, and individual. This plan reflects the understanding of these levels and the interactions between them. Representatives from one labor, seventeen
SNF, four Home Health, three Clinics, three Behavioral health, three CBO, one Developmentally Disabled organization, two NYCDOH, one Hospice agency, and one hospital comprise the initial PAC, but includes other community organizations. The network is composed of 27 nursing homes, 6 home health agencies, over 225 primary care and behavioral health professionals, 1community and 2 psychiatric hospitals, 1 LTACH, and a mix of post-acute acute and community based providers.

Plans for community advisor groups that represent geographic neighborhoods and also population-specific advisory groups such as the Chinese, Korean and other ethnic populations are under way. Community Health Workers who reflect the characteristics they serve are an important component of the engagement strategy. Responsibilities for community engagement will be housed in the DSRIP office to leverage planning, alignment, implementation and oversight across the PPS geographic region. The community engagement work stream will: 1) inventory current patient/advisory activities from PPS partners across the system; 2) identify key success factors, best practices, and effective tools; 3) define a structure and process used for advisory levels: organizational or agency council; project team advisors; program advisors; office practice advisors; committee advisors; 1:1 advisors, as in the peer to peer programs; 4) using the AHRQ Working with Patients and Families as Advisors: Implementation Handbook adopt and adapt these guidelines as needed to meet the needs of the characteristics of PPS population defined in the Community Needs Assessment; 5) develop expectations and provide training for patient engagement at the front line provider and care giver level: 6) establish processes to promote alignment and coordinate across site; provide flexibility for sites to adapt as needed based on the setting, beneficiary population and purpose; 7) Include engagement metrics on project dashboards (ex. Participating advisors; and, 8) coordinate with the Cultural Competency and Health Literacy Work stream plans.

The PPS will extend access to working with the New York State Office for Aging (NYSOFA) to establish a Chronic Disease Self-Management Program (CDSMP). The PPS does not want to compete with the NYSOFA, rather extend patient access by funding its own program. The NYSOFA is advising on local resources, program organization, and instructor training. The CNA will inform which of the CDSM Spanish programs will be offered and other populations that could benefit from the program in their native language as the CDSMP Leaders Manual is available in four languages prominent in the PPS service area: Spanish, Chinese, Hindi, and Korean.

IPQR Module 10.8 - IA Monitoring

Instructions :

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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending

Instructions :

Please include details on expected workforce spending on semi-annual basis. Total annual amounts must align with commitments in PPS application.

Funding Type	Year/Quarter										
	DY1(Q1/Q2)($)	DY1(Q3/Q4)($)	DY2(Q1/Q2)($)	DY2(Q3/Q4)($)	DY3(Q1/Q2)($)	DY3(Q3/Q4)($)	DY4(Q1/Q2)($)	DY4(Q3/Q4)($)	DY5(Q1/Q2)($)	DY5(Q3/Q4)($)	Total Spending($)
Retraining	0	0	0	0	0	0	0	0	0	0	0
Redeployment	0	0	0	0	0	0	0	0	0	0	0
Recruitment	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

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IPQR Module 11.2 - 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. Please note some milestones include minimum expected completion dates.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…Formalize Workforce Committee with charter & members	Completed	Step 1…Formalize Workforce Committee with charter & members	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2…Engage Clinical sub-committees to create a Target Workforce State Analysis that is specific to projects & outlines the workforce need and future state of workforce	In Progress	Step 2…Engage Clinical sub-committees to create a Target Workforce State Analysis that is specific to projects & outlines the workforce need and future state of workforce	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3…Complete an Organizational Impact Analysis for future workforce needs and finalize target workforce state	Not Started	Step 3…Complete an Organizational Impact Analysis for future workforce needs and finalize target workforce state	12/01/2015	02/01/2016	12/01/2015	02/01/2016	03/31/2016	DY1 Q4	
Task Step 4…Present Organizational Impact Analysis and Target Workforce State to Workforce Committee and Finance Committee for review & approval	Not Started	Step 4…Present Organizational Impact Analysis and Target Workforce State to Workforce Committee and Finance Committee for review & approval	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 4…Present Transition Roadmap to Executive Committee for review and approval of next steps	Not Started	Step 4…Present Transition Roadmap to Executive Committee for review and approval of next steps	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 1…Workforce Committee to complete a	Not Started	Step 1…Workforce Committee to complete a Current State Analysis for all PPS Partners & determine anticipated level of	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Current State Analysis for all PPS Partners & determine anticipated level of impact by project, job function, & partner		impact by project, job function, & partner							
Task Step 2…PMO & Partners to survey workforce to Establish DSRIP Workforce State of Mind Baseline (identify concerns, desires for advancements or changes, ideas to implement programmatic changes, etc.)	Not Started	Step 2…PMO & Partners to survey workforce to Establish DSRIP Workforce State of Mind Baseline (identify concerns, desires for advancements or changes, ideas to implement programmatic changes, etc.)	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3…Workforce Committee to utilize Target Workforce State Analysis and State of Mind Baseline to Create a Transition Roadmap with timing by project, job function, & partner	Not Started	Step 3…Workforce Committee to utilize Target Workforce State Analysis and State of Mind Baseline to Create a Transition Roadmap with timing by project, job function, & partner	03/01/2016	04/15/2016	03/01/2016	04/15/2016	06/30/2016	DY2 Q1	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Not Started	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1…Workforce Consultant hired to complete a Workforce Gap Analysis by project, job function, & partner utilizing partner surveys, current state analysis and target workforce state	Not Started	Step 1…Workforce Consultant hired to complete a Workforce Gap Analysis by project, job function, & partner utilizing partner surveys, current state analysis and target workforce state	12/01/2015	01/31/2016	12/01/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Step 2…Prioritize High Risk Recruitment positions & align with project need & timing	Not Started	Step 2…Prioritize High Risk Recruitment positions & align with project need & timing	01/01/2016	02/29/2016	01/01/2016	02/29/2016	03/31/2016	DY1 Q4	
Task Step 3…Analyze the current HR IT system infrastructure & outline PPS PMO infrastructure needs for ongoing monitoring (Infrastructure Gap)	Not Started	Step 3…Analyze the current HR IT system infrastructure & outline PPS PMO infrastructure needs for ongoing monitoring (Infrastructure Gap)	11/01/2015	02/29/2016	11/01/2015	02/29/2016	03/31/2016	DY1 Q4	
Task Step 4…Identify origins & destinations of staff to be redeployed & Identify Future State Demand Needs for re-deployment by project, job function, & partner	Not Started	Step 4…Identify origins & destinations of staff to be redeployed & Identify Future State Demand Needs for re-deployment by project, job function, & partner	12/01/2015	02/02/2016	12/01/2015	02/02/2016	03/31/2016	DY1 Q4	
Task	Not Started	Step 5…Present Gap Analysis and Future State Demand	03/01/2016	03/31/2016	03/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 5…Present Gap Analysis and Future State Demand Needs to the Workforce Committee and Executive Committee for approval, utilize for Transition Roadmap		Needs to the Workforce Committee and Executive Committee for approval, utilize for Transition Roadmap							
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	In Progress	Compensation and benefit analysis report, signed off by PPS workforce governance body.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1…Complete a Request for Proposal (RFP) for an independent firm to complete data gathering & analysis specific to the Compensation & Benefit Analysis deliverable	Completed	Step 1…Complete a Request for Proposal (RFP) for an independent firm to complete data gathering & analysis specific to the Compensation & Benefit Analysis deliverable	11/01/2015	01/01/2016	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2…Present RFP proposals to Executive Committee & seek approval for contract	Not Started	Step 2…Present RFP proposals to Executive Committee & seek approval for contract	12/01/2015	01/31/2016	12/01/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Step 3…Contract with RFP awarded firm to initiate Compensation & Benefit Analysis	Not Started	Step 3…Contract with RFP awarded firm to initiate Compensation & Benefit Analysis	01/15/2016	05/01/2016	01/15/2016	05/01/2016	06/30/2016	DY2 Q1	
Task Step 4…Utilize the Transition Roadmap to identify fully & partially placed staff (redeployment) by organization and project	Not Started	Step 4…Utilize the Transition Roadmap to identify fully & partially placed staff (redeployment) by organization and project	04/01/2016	05/01/2016	04/01/2016	05/01/2016	06/30/2016	DY2 Q1	
Task Step 5…Firm to complete a Compensation & Benefit Analysis for forecasted retrained, redeployed, and new hire staff associated with DSRIP projects (not based upon individualized partner proprietary or confidential information - aggregated information to be reported)	Not Started	Step 5…Firm to complete a Compensation & Benefit Analysis for forecasted retrained, redeployed, and new hire staff associated with DSRIP projects (not based upon individualized partner proprietary or confidential information - aggregated information to be reported)	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6…Present Compensation & Benefit analysis to the Executive Committee for review & approval of next steps	Not Started	Step 6…Present Compensation & Benefit analysis to the Executive Committee for review & approval of next steps	06/01/2016	06/30/2016	06/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5	In Progress	Finalized training strategy, signed off by PPS workforce	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Develop training strategy.		governance body.							
Task Step 7…Create a 5-year Training Program Outline specific to job function	Not Started	Step 7…Create a 5-year Training Program Outline specific to job function	01/01/2016	05/01/2016	01/01/2016	05/01/2016	06/30/2016	DY2 Q1	
Task Step 8…Draft a Change Management PPS Protocol for re-deployment, re-training	Not Started	Step 8…Draft a Change Management PPS Protocol for re-deployment, re-training	01/01/2016	05/01/2016	01/01/2016	05/01/2016	06/30/2016	DY2 Q1	
Task Step 9…Establish DY/annual Training Expectations by partner & job function to span the entire DSRIP program time span	Not Started	Step 9…Establish DY/annual Training Expectations by partner & job function to span the entire DSRIP program time span	01/01/2016	05/01/2016	01/01/2016	05/01/2016	06/30/2016	DY2 Q1	
Task Step 10…Present Training Expectations & Outline to Workforce Committee for review & approval	Not Started	Step 10…Present Training Expectations & Outline to Workforce Committee for review & approval	05/01/2016	08/01/2016	05/01/2016	08/01/2016	09/30/2016	DY2 Q2	
Task Step 1…Outline Regulatory Expectations of Training for all job functions impacted	Not Started	Step 1…Outline Regulatory Expectations of Training for all job functions impacted	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4	
Task Step 2…Survey Workforce on Perceived Training Needs including but not limited to PCMH, MU requirements, EHR integration, RHIO use, INTERACT, eMOLST, clinical protocols, care coordination, registries,etc	Not Started	Step 2…Survey Workforce on Perceived Training Needs including but not limited to PCMH, MU requirements, EHR integration, RHIO use, INTERACT, eMOLST, clinical protocols, care coordination, registries,etc	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4	
Task Step 3…Complete a Request for Proposal (RFP) for an independent firm to complete data gathering & analysis specific to the Compensation & Benefit Analysis deliverable	Not Started	Step 3…Complete a Request for Proposal (RFP) for an independent firm to complete data gathering & analysis specific to the Compensation & Benefit Analysis deliverable	11/01/2015	01/01/2016	11/01/2015	01/01/2016	03/31/2016	DY1 Q4	
Task Step 4…Present workforce vendor proposals to the Workforce Committee & Executive Committee to receive approval for contract with a scope of workforce training	Not Started	Step 4…Present workforce vendor proposals to the Workforce Committee & Executive Committee to receive approval for contract with a scope of workforce training	12/01/2015	01/31/2016	12/01/2015	01/31/2016	03/31/2016	DY1 Q4	
Task Step 5…Contract with a workforce vendor to complete the steps associated with this	Not Started	Step 5…Contract with a workforce vendor to complete the steps associated with this milestone & to initiate the training program	01/15/2016	05/01/2016	01/15/2016	05/01/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
milestone & to initiate the training program									
Task Step 6…Establish a PPS Training Strategy which includes IT training (including the process for tracking training participation through the PMO) and present to Workforce Committee for approval	Not Started	Step 6…Establish a PPS Training Strategy which includes IT training (including the process for tracking training participation through the PMO) and present to Workforce Committee for approval	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	
Create a workforce transition roadmap for achieving defined target workforce state.	
Perform detailed gap analysis between current state assessment of workforce and projected future state.	
Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	
Develop training strategy.	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	

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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

Please describe the key challenges and risks that you foresee in achieving the milestones set out above, including potential impacts on specific projects and any risks that will undermine your ability to achieve outcome measure targets.

Risk 1…Collaboration of all PPS partners regarding workforce strategy & change implementation
Mitigation: Establish a well balanced Workforce Committee that is properly represented by PPS partners and ensure all organizations are committed to the success of DSRIP.

Risk 2...Aligning organizations with vast diversity of HR policies, salaries, benefits to create synergy among the employee pool
Mitigation: Allow for uniqueness of HR practices within organizations while ensuring project requirements and milestones are met. Maximize relationship with unions in order to allow for large workgroup impacts

Risk 3... Compliance with legal/regulatory requirements governing collaboration on workforce strategy and sharing of information among partners of the PPS.
Mitigation: The Workforce Committee will work with legal council to establish protocols and provide training for compliant activity; seek approval of Certificate of Public Advantage, as appropriate.

Risk 4...Ability to train & re-deploy staff in a timely manner in accordance with the timing of each project.
Mitigation: A detailed roadmap with timelines will be created (Milestone above) and cross-referenced to the overall project requirement timeline (speed, scale, & operational expectations) to identify risks and plan for alternative developments

Risk 5...Capability of the workforce pool to make rapid evolutions to positions or training expectations as defined by the Workforce Committee or clinical integration process
Mitigation: The Workforce Committee and PPS partners will work closely with 1199 and other unions as well as HR leadership to develop options for employee engagement to ensure understanding and interaction during the process

Risk 6...Workforce shortages and recruitment difficulties due to local shortages as well as state-wide competition with new DSRIP programs
Mitigation: Partner with 1199 and local recruitment organizations to properly identify shortage areas and job functions and plan accordingly with the Clinical Governing Committees to identify potential impacts to outcomes. Create a competitive work environment with respect to salary, training, and opportunities for growth.

IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

Instructions :

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

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The Workforce section of the DSRIP plan has major dependencies related to most Organizational functions as well as all projects assigned by the PPS. Examples of dependencies include (but are not limited to):

Cultural Competency & Health Literacy - The foundational processes of ensuring a culturally competent healthcare environment will require workforce training and/or retraining based on the service area or service type provided. The training will be an integral part of the Workforce planning & development to ensure proper funding of training, establishment of expectations, and continuation of training to ensure long-term quality improvements.

IT Systems & Processes - PPS partners vary in regards to IT systems and processes as each have unique processes and use of electronic medical record system (or lack there of). All projects contain a component of data sharing or information exchange that will require training or particular skill-sets to ensure the successful implementation of the IT requirements. The Workforce Committee will be mindful of this dynamic while completing the current state analysis and training program.

Funds Flow & Budgeting - As the PPS establishes funds flow expectations that are coupled with top-down and bottom-up budgets, workforce will be a large component of the financial planning in order to adequately staff projects based on current & forecasted states. All committees and workgroups will include expectations of workforce planning in their charter to ensure adequate communication to the finance committee.

Clinical Integration - The successful integration of new clinical requirements into existing workflows will hinge on proper training, staffing, and re-deployment of staff to allow for best practice implementation. Robust communication channels will be established between all committees and operational stakeholders to ensure a rapid response system of issues related to workforce issues.

Practitioner Engagement - Practitioner engagement will tie to Workforce in two main veins; (1) impact of the surrounding workforce in order to implement requirements and achieve goals, and (2) recruitment of practitioners in order to clinically staff projects and meet speed and scale expectations. The direct relation will be addressed in both the Workforce planning as well as the Practitioner Engagement/Communications workgroup that will be formalized.

Projects - All projects are dependent on Workforce as the core principal of DSRIP is to transform the healthcare of our community. Project requirements cannot be implemented or goals and milestones met without the proper development of a dynamic Workforce strategy that will continuously evolve by distribution year to allow for market developments or partner changes. The clinical workgroups will have a direct line of communication to the Workforce Committee.

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IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Workforce Committee - Chair (Human Resources Representative)	Lorraine Orlando - NYP/Q	Manage Workforce Committee to ensure completion of Milestones Ensure transparency & collaboration among all partners Present monthly/quarter updates to the Executive Committee regarding workforce developments
Workforce Committee - Vice Chair	MiMi Lim - NYP/Q	Provide support to the Chair and Committee as a lead role Ensure progression of discussions & planning to ensure successful deliverable completion
Workforce Committee - Secretary	Dina Pantelias- NYP/Q	Ensure committee meetings & structure are representative of PPS expectations Notation of minutes of meetings Ensure proper voting of all actionable items
Workforce Committee - Employee Representative	Wendy Louie- NYP/Q	Actively participate in committee discussions & decision making Become a voice for employees to ensure all levels of discussions & transparency
Workforce Committee - Members	Glenn Courounis, Centerlight Health System Pietro Piacquadio, Avanti Health Care Services Jessica Kozikott, Parker Jewish Institute Jerry Enella, Flushing Manor Nursing & Rehab John Lavin, MHPWQ Sarah McQuade, MHPWQ John Burke, MHPWQ Maureen Buglino, NYP/Q Maria D'Urso, NYP/Q Marissa Schwartz, QBECF Felix Rosado, Americare Suzanne Pugh, NYP/Q	Actively participate in committee discussions & decision making Become a liaison between the committee and partnering organizations or providers to provide updates regarding progress or policies

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	Margaret Cartmell, NYP/Q Michael Tretola, Silvercrest Vivian Torres, Selfhelp Community Services Michaelle Williams, NYP/Q Russell Lusak, SelfHelp Community Services	

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IPQR Module 11.7 - Key Stakeholders

Instructions :

Please identify the key stakeholders involved in your workforce transformation plans, both within and outside the PPS.

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Human Resource Representatives	Direction of organization(s) needs & commitments Liaison & communicator to partnering organizations	Provide guidance & organizational expectations regarding recruitment, retraining, redeployment, and reduction in staff
Legal Counsel Representatives	Direction of organization(s) needs & commitments Liaison & communicator to partnering organizations	Provide guidance & organizational expectations regarding recruitment, retraining, redeployment, and reduction in staff
Training Organizations	Resource of training plans & needs	Provide feedback &/or materials on training strategy, plan, and materials
External Stakeholders		
Bordering PPS partners	Cross PPS collaboration	Engage in collaborative meetings to allow for cross PPS transparency and synergy
Recruitment Firms	Potential partnership for recruitment	Provide guidance & potential hired services for recruitment
Labor Union Representatives- 1199SEIU	Representation of unionized labor Resource to ensure compliance with labor regulations	Communication among union representatives and labor to ensure transparency & positive collaboration for plans

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IPQR Module 11.8 - IT Expectations

Instructions :

Please describe how the development of shared IT infrastructure across the PPS will support your plans for workforce transformation.

The concept of a shared IT infrastructure will support the plans for workforce transformation by allowing consistency to training modules and expectations in regards to patient care, cultural competency & health literacy, or IT processes. Shared data will allow for a source of information pertaining to quality and care that will inform training needs. Training systems across the organizations will be a critical element of the IT infrastructure to ensure ease of training and consistency among partners. The development of an IT data repository will be a focus of the Workforce Committee to allow for warehousing of pertinent and legally shared information regarding HR at the PPS PMO level to track, trend, and report quickly and easily throughout the governing processes of the PPS.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

The Workforce Committee along with the PPS Project Management Office (PMO) will establish a Workforce Dashboard Reporting Tool (Milestone above) that will outline deliverables, risks, communication strategies, etc. for all functions related to workforce (training, recruitment, re-deployment, reduction). This tool will be used as a communication and accountability tool for all actionable items pertaining to workforce development. The reporting tool will rely on the input of the Workforce Committee as well as all PPS partners.

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IPQR Module 11.10 - Staff Impact

Instructions :

Please include details on workforce staffing impacts on an annual basis. For each DSRIP year, please indicate the number of individuals in each of the categories below that will be impacted. 'Impacted' is defined as those individuals that are retrained, redeployed, recruited, or whose employment is otherwise affected.

Staff Type	Workforce Staffing Impact Analysis					
	DY1	DY2	DY3	DY4	DY5	Total Impact
Physicians	**0**	**0**	**0**	**0**	**0**	**0**
Primary Care	0	0	0	0	0	**0**
Other Specialties (Except Psychiatrists)	0	0	0	0	0	**0**
Physician Assistants	**0**	**0**	**0**	**0**	**0**	**0**
Primary Care	0	0	0	0	0	**0**
Other Specialties	0	0	0	0	0	**0**
Nurse Practitioners	**0**	**0**	**0**	**0**	**0**	**0**
Primary Care	0	0	0	0	0	**0**
Other Specialties (Except Psychiatric NPs)	0	0	0	0	0	**0**
Midwives	**0**	**0**	**0**	**0**	**0**	**0**
Midwives	0	0	0	0	0	**0**
Nursing	**0**	**0**	**0**	**0**	**0**	**0**
Nurse Managers/Supervisors	0	0	0	0	0	**0**
Staff Registered Nurses	0	0	0	0	0	**0**
Other Registered Nurses (Utilization Review, Staff Development, etc.)	0	0	0	0	0	**0**
LPNs	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**
Clinical Support	**0**	**0**	**0**	**0**	**0**	**0**
Medical Assistants	0	0	0	0	0	**0**
Nurse Aides/Assistants	0	0	0	0	0	**0**
Patient Care Techs	0	0	0	0	0	**0**

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Staff Type	Workforce Staffing Impact Analysis					
	DY1	DY2	DY3	DY4	DY5	Total Impact
Clinical Laboratory Technologists and Technicians	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**
Behavioral Health (Except Social Workers providing Case/Care Management, etc.)	**0**	**0**	**0**	**0**	**0**	**0**
Psychiatrists	0	0	0	0	0	**0**
Psychologists	0	0	0	0	0	**0**
Psychiatric Nurse Practitioners	0	0	0	0	0	**0**
Licensed Clinical Social Workers	0	0	0	0	0	**0**
Substance Abuse and Behavioral Disorder Counselors	0	0	0	0	0	**0**
Other Mental Health/Substance Abuse Titles Requiring Certification	0	0	0	0	0	**0**
Social and Human Service Assistants	0	0	0	0	0	**0**
Psychiatric Aides/Techs	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**
Nursing Care Managers/Coordinators/Navigators/Coaches	**0**	**0**	**0**	**0**	**0**	**0**
RN Care Coordinators/Case Managers/Care Transitions	0	0	0	0	0	**0**
LPN Care Coordinators/Case Managers	0	0	0	0	0	**0**
Social Worker Case Management/Care Management	**0**	**0**	**0**	**0**	**0**	**0**
Bachelor's Social Work	0	0	0	0	0	**0**
Licensed Masters Social Workers	0	0	0	0	0	**0**
Social Worker Care Coordinators/Case Managers/Care Transition	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**
Non-licensed Care Coordination/Case Management/Care Management/Patient Navigators/Community Health Workers (Except RNs, LPNs, and Social Workers)	**0**	**0**	**0**	**0**	**0**	**0**
Care Manager/Coordinator (Bachelor's degree required)	0	0	0	0	0	**0**
Care or Patient Navigator	0	0	0	0	0	**0**
Community Health Worker (All education levels and training)	0	0	0	0	0	**0**

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Staff Type	Workforce Staffing Impact Analysis					
	DY1	DY2	DY3	DY4	DY5	Total Impact
Peer Support Worker (All education levels)	0	0	0	0	0	**0**
Other Requiring High School Diplomas	0	0	0	0	0	**0**
Other Requiring Associates or Certificate	0	0	0	0	0	**0**
Other Requiring Bachelor's Degree or Above	0	0	0	0	0	**0**
Other Requiring Master's Degree or Above	0	0	0	0	0	**0**
Patient Education	**0**	**0**	**0**	**0**	**0**	**0**
Certified Asthma Educators	0	0	0	0	0	**0**
Certified Diabetes Educators	0	0	0	0	0	**0**
Health Coach	0	0	0	0	0	**0**
Health Educators	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**
Administrative Staff -- All Titles	**0**	**0**	**0**	**0**	**0**	**0**
Executive Staff	0	0	0	0	0	**0**
Financial	0	0	0	0	0	**0**
Human Resources	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**
Administrative Support -- All Titles	**0**	**0**	**0**	**0**	**0**	**0**
Office Clerks	0	0	0	0	0	**0**
Secretaries and Administrative Assistants	0	0	0	0	0	**0**
Coders/Billers	0	0	0	0	0	**0**
Dietary/Food Service	0	0	0	0	0	**0**
Financial Service Representatives	0	0	0	0	0	**0**
Housekeeping	0	0	0	0	0	**0**
Medical Interpreters	0	0	0	0	0	**0**
Patient Service Representatives	0	0	0	0	0	**0**
Transportation	0	0	0	0	0	**0**

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Staff Type	Workforce Staffing Impact Analysis					
	DY1	DY2	DY3	DY4	DY5	Total Impact
Other	0	0	0	0	0	**0**
Janitors and cleaners	**0**	**0**	**0**	**0**	**0**	**0**
Janitors and cleaners	0	0	0	0	0	**0**
Health Information Technology	**0**	**0**	**0**	**0**	**0**	**0**
Health Information Technology Managers	0	0	0	0	0	**0**
Hardware Maintenance	0	0	0	0	0	**0**
Software Programmers	0	0	0	0	0	**0**
Technical Support	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**
Home Health Care	**0**	**0**	**0**	**0**	**0**	**0**
Certified Home Health Aides	0	0	0	0	0	**0**
Personal Care Aides	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**
Other Allied Health	**0**	**0**	**0**	**0**	**0**	**0**
Nutritionists/Dieticians	0	0	0	0	0	**0**
Occupational Therapists	0	0	0	0	0	**0**
Occupational Therapy Assistants/Aides	0	0	0	0	0	**0**
Pharmacists	0	0	0	0	0	**0**
Pharmacy Technicians	0	0	0	0	0	**0**
Physical Therapists	0	0	0	0	0	**0**
Physical Therapy Assistants/Aides	0	0	0	0	0	**0**
Respiratory Therapists	0	0	0	0	0	**0**
Speech Language Pathologists	0	0	0	0	0	**0**
Other	0	0	0	0	0	**0**

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Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 11.11 - IA Monitoring:

Instructions :

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Project 2.a.ii – Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))

IPQR Module 2.a.ii.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.

Risk #1: The timing associated with the successful attainment of the PCPs to meet the NCQA 2014 Level 3 PCMH accreditation and/or the state-determined criteria for Advanced Primary Care Models by the end of Demonstration Year (DY) 3.

Mitigation #1: Identify and leverage a PCP champion in the primary care practices to motivate and mobilize with existing practices that are at various stages of recognition to attain this level, using clinical integration strategies to align the PCPs and the PPS, and closely monitor progress to milestones and metrics. Using best practices in project management to monitor progress and ensure effective implementation staging will help to support team members. Based on current state, develop a schedule for completion and provide technical assistance to ensure successful achievement of PCMH certification. Overall, the PPS will need to ensure collaboration with PCMH initiatives and coordinate timing of implementation plan with PCMH.

Risk #2: Inter-dependencies between PCMH certification and the other projects. Many of the other projects chosen by the PPS require a successful implementation of PCMH Level 3.

Mitigation #2: The PPS will create a realistic timeline and phased approach to implementation of projects to ensure that the deliverables that are interdependent are appropriately coordinated.

Risk #3: The level of diversity in the PPS catchment basin and the cultural challenges associated with patient engagement, health literacy and communication with providers.

Mitigation #3: Strategies would include processes for engaging patient through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations to garner a care transition partnership with this culturally diverse population. This project will need to align closely with the Cultural Competency / Health Literacy work stream for the roles of community health workers, community councils, and health literacy improvements.

Risk #4: Implementation and/or maximization of Electronic Medical Record across all PPS partners to ensure data sharing & integrity for all patients involved. This risk will be impacted by the results of the CRFP NYS process, as the PPS will rely on capital funding to ensure connection of all partners.

Mitigation #4: The implementation plan will have a detailed IT roadmap that will include a plan for all partners involved in the projects in order to maximize existing products or networks for data sharing & security measures.

Risk #5: The PCMH project will require many workflow changes to meet Level 3 NCQA accreditation which will require staff training as well as culture changes across the PPS.

Mitigation #5: The Workforce and Clinical Integration Committees will include the hiring of an independent consultant, HANYs Solutions, focused to PCMH certification & staff expectations and will build training for skill and change management into the budget of the project.

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IPQR Module 2.a.ii.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	9,449

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
2,741	6,668	348.56%	-4,755	70.57%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cc599179	Documentation/Certification	40_PMDL2115_1_3_20160202153603_NYPQ_PCMH_2.a.ii.xlsx	PCMH 2.a.ii engaged patients	02/02/2016 03:38 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 2.a.ii.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Utilize previously completed partner surveys to identify a current state survey of all partners PCMH level, year, and status. Survey additional partners as needed.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Contract with a PCMH expert consulting firm to outline plan and expectations of all PPS partners to become level 3 PCMH certified.	Project		Completed	07/01/2015	09/01/2015	07/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 3…Create a roadmap including a timeline with PPS partners placed in zones of certification tasks & completion due dates to ensure DY3 completion of all.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4...Align roadmap with executed partner agreements to ensure appropriate timeline and accountability of partners for NCQA PCMH certification.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5…Update Performance Logic with the PCMH road map and timelines to include in PMO & PPS tracking and reporting processes.	Project		Not Started	01/01/2016	03/03/2016	01/01/2016	03/03/2016	03/31/2016	DY1 Q4
Milestone #2 Identify a physician champion with knowledge of PCMH/APCM	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
implementation for each primary care practice included in the project.									
Task PPS has identified physician champion with experience implementing PCMHs/ACPMs.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Include physician champion training tools & sessions in the contracting with the PCMH consulting firm.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Identify expectations and duties of the physician champion, publish, and seek approval of the Clinical Integration Committee of the role & expectations.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Engage each primary care organization/partner to identify a physician champion per site.	Project		Not Started	01/01/2016	07/01/2016	01/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 4…Present physician champions by site to the PCMH clinical sub-committee.	Project		Not Started	07/01/2016	09/01/2016	07/01/2016	09/01/2016	09/30/2016	DY2 Q2
Task Step 5…Create an ongoing physician champion education process utilizing the rapid cycle evaluation team data & PCMH updates to focus educational needs. Create CME credits if available to incentivize participation.	Project		Not Started	07/01/2016	02/01/2017	07/01/2016	02/01/2017	03/31/2017	DY2 Q4
Task Step 6…Ensure all physician champions are members of the PCMH clinical sub-committee to allow for networking, clinical updates, etc.	Project		Not Started	09/01/2016	11/01/2016	09/01/2016	11/01/2016	12/31/2016	DY2 Q3
Milestone #3 Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordinators are identified for each primary care site.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinical Interoperability System in place for all participating	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
providers and document usage by the identified care coordinators.									
Task Step 1…Identify care coordinators already located at PCMH sites & document findings to identify needs for deployment of new staff or expand on existing staff responsibilities.	Project		Completed	09/01/2015	01/01/2016	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2…Define general responsibilities of the care coordinators to ensure alignment with PCMH expectations.	Project		Completed	09/01/2015	12/01/2015	09/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…Utilize Step 1 findings to inform the clinical budgeting process for funding options of non-covered service of care coordination.	Project		Completed	09/01/2015	01/01/2016	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Create a plan that outlines the timeline for recruitment/re-deployment and/or re-training by partner that aligns with Milestone 1 with an expectation of DY3 completion of PCMH certification.	Project		In Progress	09/01/2015	03/01/2016	09/01/2015	03/01/2016	03/31/2016	DY1 Q4
Task Step 5…Utilize the HANYs Solutions training program for provider & staff training for PPS partners.	Project		In Progress	09/01/2015	03/01/2017	09/01/2015	03/01/2017	03/31/2017	DY2 Q4
Task Step 6...Care coordinators to provider data and feedback on PCMH as required by PMO to be incorporated for tracking and improvement mechanisms.	Project		In Progress	09/01/2015	03/01/2017	09/01/2015	03/01/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Utilize surveys previously completed or outlined in the	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
IT Organization Implementation Plan to identify the current state of IT of all partners to include EHR, RHIO, Other product use for data sharing/exchange.									
Task Step 2…Use the data collected in Step 1, Milestone 1, and the IT Organization Implementation Plan to align IT gaps with the clinical plan to implement projects.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…Partner the IT team and HANYs Solutions to ensure alignment of the PCMH roadmap, expectations, and IT strategy.	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 4…Executive Committee to review & approve recommendations for EMR use to have available for paper documenting partners.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
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.	Project	N/A	In Progress	07/01/2015	03/31/2018	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	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	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Utilize surveys previously completed or outlined in the IT Organization Implementation Plan to identify the current state of Meaningful Use & PCMH standards to inform the roll-out process of PCMH certification to Level 3.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…HANYs Solutions, PCMH consultant, to work with all partners to outline expectations of Meaningful Use & PCMH Level 3 standards. Steps will be identified specific to each partner or process needed for MU or PCMH Level 3 certification.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 3…PMO staff to load information into Performance Logic,	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PMO tracking tool, to properly track EMR progress.									
Task Step 4...Align partner agreements to ensure participation and accountability of meeting MU and PCMH standards for EMR systems.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
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.	Project	N/A	In Progress	07/01/2015	03/31/2017	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	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize existing Population Health Management IT tool, Allscripts Care Director, to identify and track attributed lives by creating registries for all participating safety net providers.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2…Identify gaps of providers without access to Allscripts Care Director any other PHM tool.	Project		Completed	07/01/2015	09/01/2015	07/01/2015	09/01/2015	09/30/2015	DY1 Q2
Task Step 3…Create an action plan to implement a similar/universal Population Health Management tool (Allscripts Care Director) for partners currently not using a tool.	Project		In Progress	10/01/2015	11/30/2015	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Step 4…Expand existing Population Health Management tool contracts or create new contracts for new vendors to create registries for all partners.	Project		Not Started	12/01/2015	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task Step 5…Establish expectations for use of the Population Health Management tool for the attributed patients for all partners involved; submit guidelines to the PCMH sub-committee for review for final approval by the Clinical Integration Committee.	Project		In Progress	10/01/2015	11/30/2015	10/01/2015	05/01/2016	06/30/2016	DY2 Q1
Task Step 6…Create a training program for the roll-out and maintenance of Allscripts Care Director.	Project		In Progress	10/01/2015	11/30/2015	10/01/2015	06/01/2016	06/30/2016	DY2 Q1
Task Step 7…Establish reporting expectations of monthly & quarterly	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
for items identified for patient registries to the PMO for submission to the PCMH sub-committee and Clinical Integration Committee.									
Milestone #7 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.	Project	N/A	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Practice has adopted preventive and chronic care protocols aligned with national guidelines.	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Utilize the contract with HANYs Solutions to outline a training protocol for staff and providers to include PCMH/Advanced Primary Care models including chronic disease management protocols.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2…Present the training plan to the PCMH clinical sub-committee for review & recommendation to the Clinical Integration Committee for final approval.	Project		Not Started	12/01/2015	02/29/2016	01/01/2016	02/29/2016	03/31/2016	DY1 Q4
Task Step 3…Create a roll-out schedule of training for staff and providers to include initial training, re-training, and expectations for annual re-training; present to PCMH clinical sub-committee, and seek approval from the Clinical Integration Committee.	Project		Not Started	12/01/2015	02/29/2016	01/01/2016	02/29/2016	03/31/2016	DY1 Q4
Task Step 4…Utilize the information in Steps 1-3 to present to the Workforce Committee for review & inform the Workforce budget for staff training.	Project		Not Started	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5... Train staff using approved training modules and document attendance in training.	Project		Not Started	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #8 Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
process is developed for assuring referral to appropriate care in a timely manner.									
Task Preventive care screenings implemented among participating PCPs, including behavioral health screenings (PHQ-2 or 9, SBIRT).	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Protocols and processes for referral to appropriate services are in place.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Survey partners to identify partners currently utilizing preventive care screening protocols, including behavioral health, to identify current best practices.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Discuss clinical best practices with bordering PPS's to align clinical practices to ensure provider continuity.	Project		In Progress	10/01/2015	04/01/2016	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Step 3…Present Step 1 best practices to the PCMH clinical sub-committee for review & recommendations for PPS sponsored best practices for practice implementation during PCMH site certification.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Create a communication & implementation schedule of the best practices identified in Step 2 for all practice sites.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5…Identify staff training needs associated with new or existing best practice protocols; create a training schedule & inform the Workforce budget of training needs.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6…Create a quarterly reporting expectation of all partners to identify use of measure on allocated patients, practice needs, or trends.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #9 Implement open access scheduling in all primary care practices.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Provider	Practitioner - Primary	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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DSRIP Implementation Plan Project

NewYork-Presbyterian/Queens (PPS ID:40)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.		Care Provider (PCP)							
Task PPS monitors and decreases no-show rate by at least 15%.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize previously completed surveys or complete needed surveys to identify the current use of open access scheduling; identify implementation gaps.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Define open access PPS operational expectations/best practice, present to the clinical sub-committee and seek approval of the Clinical Integration Committee.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…Communicate PPS best practice to PPS partners with a defined timing expectation of implementation.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4…PMO staff to work with PPS partners to implement process and provide an ongoing resource for education, process questions, or communication channels.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5... PMO to collect feedback & data from PPS partners on open scheduling process- data points will potentially include information on patient experience, wait time, no show rates	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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 Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	0	2	5	8	12	17	23
Task Step 1…Utilize previously completed partner surveys to identify a current state survey of all partners PCMH level, year, and status. Survey additional partners as needed.										

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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
Task Step 2…Contract with a PCMH expert consulting firm to outline plan and expectations of all PPS partners to become level 3 PCMH certified.										
Task Step 3…Create a roadmap including a timeline with PPS partners placed in zones of certification tasks & completion due dates to ensure DY3 completion of all.										
Task Step 4...Align roadmap with executed partner agreements to ensure appropriate timeline and accountability of partners for NCQA PCMH certification.										
Task Step 5…Update Performance Logic with the PCMH road map and timelines to include in PMO & PPS tracking and reporting processes.										
Milestone #2 Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.										
Task PPS has identified physician champion with experience implementing PCMHs/ACPMs.	0	0	0	0	2	5	8	12	17	23
Task Step 1…Include physician champion training tools & sessions in the contracting with the PCMH consulting firm.										
Task Step 2…Identify expectations and duties of the physician champion, publish, and seek approval of the Clinical Integration Committee of the role & expectations.										
Task Step 3…Engage each primary care organization/partner to identify a physician champion per site.										
Task Step 4…Present physician champions by site to the PCMH clinical sub-committee.										
Task Step 5…Create an ongoing physician champion education process utilizing the rapid cycle evaluation team data & PCMH updates to focus educational needs. Create CME credits if available to incentivize participation.										
Task Step 6…Ensure all physician champions are members of the										

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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
PCMH clinical sub-committee to allow for networking, clinical updates, etc.										
Milestone #3 Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.										
Task Care coordinators are identified for each primary care site.	0	0	0	0	2	5	8	12	17	23
Task Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities.	0	0	0	0	2	5	8	12	17	23
Task Clinical Interoperability System in place for all participating providers and document usage by the identified care coordinators.										
Task Step 1…Identify care coordinators already located at PCMH sites & document findings to identify needs for deployment of new staff or expand on existing staff responsibilities.										
Task Step 2…Define general responsibilities of the care coordinators to ensure alignment with PCMH expectations.										
Task Step 3…Utilize Step 1 findings to inform the clinical budgeting process for funding options of non-covered service of care coordination.										
Task Step 4…Create a plan that outlines the timeline for recruitment/re-deployment and/or re-training by partner that aligns with Milestone 1 with an expectation of DY3 completion of PCMH certification.										
Task Step 5…Utilize the HANYs Solutions training program for provider & staff training for PPS partners.										
Task Step 6...Care coordinators to provider data and feedback on PCMH as required by PMO to be incorporated for tracking and improvement mechanisms.										
Milestone #4 Ensure all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.										

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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
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	2	5	8	12	17	19
Task PPS uses alerts and secure messaging functionality.										
Task Step 1…Utilize surveys previously completed or outlined in the IT Organization Implementation Plan to identify the current state of IT of all partners to include EHR, RHIO, Other product use for data sharing/exchange.										
Task Step 2…Use the data collected in Step 1, Milestone 1, and the IT Organization Implementation Plan to align IT gaps with the clinical plan to implement projects.										
Task Step 3…Partner the IT team and HANYs Solutions to ensure alignment of the PCMH roadmap, expectations, and IT strategy.										
Task Step 4…Executive Committee to review & approve recommendations for EMR use to have available for paper documenting partners.										
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.	0	0	0	0	2	5	8	12	17	19
Task Step 1…Utilize surveys previously completed or outlined in the IT Organization Implementation Plan to identify the current state of Meaningful Use & PCMH standards to inform the roll-out process of PCMH certification to Level 3.										
Task Step 2…HANYs Solutions, PCMH consultant, to work with all partners to outline expectations of Meaningful Use & PCMH Level 3 standards. Steps will be identified specific to each partner or process needed for MU or PCMH Level 3 certification.										
Task										

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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
Step 3…PMO staff to load information into Performance Logic, PMO tracking tool, to properly track EMR progress.										
Task Step 4...Align partner agreements to ensure participation and accountability of meeting MU and PCMH standards for EMR systems.										
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 PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Utilize existing Population Health Management IT tool, Allscripts Care Director, to identify and track attributed lives by creating registries for all participating safety net providers.										
Task Step 2…Identify gaps of providers without access to Allscripts Care Director any other PHM tool.										
Task Step 3…Create an action plan to implement a similar/universal Population Health Management tool (Allscripts Care Director) for partners currently not using a tool.										
Task Step 4…Expand existing Population Health Management tool contracts or create new contracts for new vendors to create registries for all partners.										
Task Step 5…Establish expectations for use of the Population Health Management tool for the attributed patients for all partners involved; submit guidelines to the PCMH sub-committee for review for final approval by the Clinical Integration Committee.										
Task Step 6…Create a training program for the roll-out and maintenance of Allscripts Care Director.										
Task Step 7…Establish reporting expectations of monthly & quarterly for items identified for patient registries to the PMO for submission to the PCMH sub-committee and Clinical Integration Committee.										

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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 #7 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.										
Task Practice has adopted preventive and chronic care protocols aligned with national guidelines.										
Task Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.	0	0	0	0	2	5	8	12	17	23
Task Step 1…Utilize the contract with HANYs Solutions to outline a training protocol for staff and providers to include PCMH/Advanced Primary Care models including chronic disease management protocols.										
Task Step 2…Present the training plan to the PCMH clinical sub-committee for review & recommendation to the Clinical Integration Committee for final approval.										
Task Step 3…Create a roll-out schedule of training for staff and providers to include initial training, re-training, and expectations for annual re-training; present to PCMH clinical sub-committee, and seek approval from the Clinical Integration Committee.										
Task Step 4…Utilize the information in Steps 1-3 to present to the Workforce Committee for review & inform the Workforce budget for staff training.										
Task Step 5... Train staff using approved training modules and document attendance in training.										
Milestone #8 Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.										
Task Preventive care screenings implemented among participating PCPs, including behavioral health screenings (PHQ-2 or 9, SBIRT).	0	0	0	0	2	5	8	12	17	23
Task Protocols and processes for referral to appropriate services are in place.										

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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
Task Step 1…Survey partners to identify partners currently utilizing preventive care screening protocols, including behavioral health, to identify current best practices.										
Task Step 2…Discuss clinical best practices with bordering PPS's to align clinical practices to ensure provider continuity.										
Task Step 3…Present Step 1 best practices to the PCMH clinical sub-committee for review & recommendations for PPS sponsored best practices for practice implementation during PCMH site certification.										
Task Step 4…Create a communication & implementation schedule of the best practices identified in Step 2 for all practice sites.										
Task Step 5…Identify staff training needs associated with new or existing best practice protocols; create a training schedule & inform the Workforce budget of training needs.										
Task Step 6…Create a quarterly reporting expectation of all partners to identify use of measure on allocated patients, practice needs, or trends.										
Milestone #9 Implement open access scheduling in all primary care practices.										
Task PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.	0	0	0	0	2	5	8	12	17	23
Task PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.	0	0	0	0	2	5	8	12	17	23
Task PPS monitors and decreases no-show rate by at least 15%.	0	0	0	0	2	5	8	12	17	23
Task Step 1…Utilize previously completed surveys or complete needed surveys to identify the current use of open access scheduling; identify implementation gaps.										
Task Step 2…Define open access PPS operational expectations/best practice, present to the clinical sub-committee and seek approval of the Clinical Integration Committee.										
Task Step 3…Communicate PPS best practice to PPS partners with a										

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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
defined timing expectation of implementation.										
Task Step 4…PMO staff to work with PPS partners to implement process and provide an ongoing resource for education, process questions, or communication channels.										
Task Step 5... PMO to collect feedback & data from PPS partners on open scheduling process- data points will potentially include information on patient experience, wait time, no show rates										

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
Milestone #1 Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	29	36	36	36	36	36	36	36	36	36
Task Step 1…Utilize previously completed partner surveys to identify a current state survey of all partners PCMH level, year, and status. Survey additional partners as needed.										
Task Step 2…Contract with a PCMH expert consulting firm to outline plan and expectations of all PPS partners to become level 3 PCMH certified.										
Task Step 3…Create a roadmap including a timeline with PPS partners placed in zones of certification tasks & completion due dates to ensure DY3 completion of all.										
Task Step 4...Align roadmap with executed partner agreements to ensure appropriate timeline and accountability of partners for NCQA PCMH certification.										
Task Step 5…Update Performance Logic with the PCMH road map and timelines to include in PMO & PPS tracking and reporting processes.										
Milestone #2 Identify a physician champion with knowledge of PCMH/APCM										

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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
implementation for each primary care practice included in the project.										
Task PPS has identified physician champion with experience implementing PCMHs/ACPMs.	29	36	36	36	36	36	36	36	36	36
Task Step 1…Include physician champion training tools & sessions in the contracting with the PCMH consulting firm.										
Task Step 2…Identify expectations and duties of the physician champion, publish, and seek approval of the Clinical Integration Committee of the role & expectations.										
Task Step 3…Engage each primary care organization/partner to identify a physician champion per site.										
Task Step 4…Present physician champions by site to the PCMH clinical sub-committee.										
Task Step 5…Create an ongoing physician champion education process utilizing the rapid cycle evaluation team data & PCMH updates to focus educational needs. Create CME credits if available to incentivize participation.										
Task Step 6…Ensure all physician champions are members of the PCMH clinical sub-committee to allow for networking, clinical updates, etc.										
Milestone #3 Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.										
Task Care coordinators are identified for each primary care site.	29	36	36	36	36	36	36	36	36	36
Task Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities.	29	36	36	36	36	36	36	36	36	36
Task Clinical Interoperability System in place for all participating providers and document usage by the identified care coordinators.										
Task Step 1…Identify care coordinators already located at PCMH sites & document findings to identify needs for deployment of new staff										

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
or expand on existing staff responsibilities.										
Task Step 2…Define general responsibilities of the care coordinators to ensure alignment with PCMH expectations.										
Task Step 3…Utilize Step 1 findings to inform the clinical budgeting process for funding options of non-covered service of care coordination.										
Task Step 4…Create a plan that outlines the timeline for recruitment/re-deployment and/or re-training by partner that aligns with Milestone 1 with an expectation of DY3 completion of PCMH certification.										
Task Step 5…Utilize the HANYs Solutions training program for provider & staff training for PPS partners.										
Task Step 6...Care coordinators to provider data and feedback on PCMH as required by PMO to be incorporated for tracking and improvement mechanisms.										
Milestone #4 Ensure all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	19	19	19	19	19	19	19	19	19	19
Task PPS uses alerts and secure messaging functionality.										
Task Step 1…Utilize surveys previously completed or outlined in the IT Organization Implementation Plan to identify the current state of IT of all partners to include EHR, RHIO, Other product use for data sharing/exchange.										
Task Step 2…Use the data collected in Step 1, Milestone 1, and the IT Organization Implementation Plan to align IT gaps with the clinical plan to implement projects.										
Task Step 3…Partner the IT team and HANYs Solutions to ensure alignment of the PCMH roadmap, expectations, and IT strategy.										

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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 Step 4…Executive Committee to review & approve recommendations for EMR use to have available for paper documenting partners.										
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.	19	19	19	19	19	19	19	19	19	19
Task Step 1…Utilize surveys previously completed or outlined in the IT Organization Implementation Plan to identify the current state of Meaningful Use & PCMH standards to inform the roll-out process of PCMH certification to Level 3.										
Task Step 2…HANYs Solutions, PCMH consultant, to work with all partners to outline expectations of Meaningful Use & PCMH Level 3 standards. Steps will be identified specific to each partner or process needed for MU or PCMH Level 3 certification.										
Task Step 3…PMO staff to load information into Performance Logic, PMO tracking tool, to properly track EMR progress.										
Task Step 4...Align partner agreements to ensure participation and accountability of meeting MU and PCMH standards for EMR systems.										
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 PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Utilize existing Population Health Management IT tool, Allscripts Care Director, to identify and track attributed lives by creating registries for all participating safety net providers.										

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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 Step 2…Identify gaps of providers without access to Allscripts Care Director any other PHM tool.										
Task Step 3…Create an action plan to implement a similar/universal Population Health Management tool (Allscripts Care Director) for partners currently not using a tool.										
Task Step 4…Expand existing Population Health Management tool contracts or create new contracts for new vendors to create registries for all partners.										
Task Step 5…Establish expectations for use of the Population Health Management tool for the attributed patients for all partners involved; submit guidelines to the PCMH sub-committee for review for final approval by the Clinical Integration Committee.										
Task Step 6…Create a training program for the roll-out and maintenance of Allscripts Care Director.										
Task Step 7…Establish reporting expectations of monthly & quarterly for items identified for patient registries to the PMO for submission to the PCMH sub-committee and Clinical Integration Committee.										
Milestone #7 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.										
Task Practice has adopted preventive and chronic care protocols aligned with national guidelines.										
Task Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.	29	36	36	36	36	36	36	36	36	36
Task Step 1…Utilize the contract with HANYs Solutions to outline a training protocol for staff and providers to include PCMH/Advanced Primary Care models including chronic disease management protocols.										
Task Step 2…Present the training plan to the PCMH clinical sub-committee for review & recommendation to the Clinical Integration Committee for final approval.										

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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 Step 3…Create a roll-out schedule of training for staff and providers to include initial training, re-training, and expectations for annual re-training; present to PCMH clinical sub-committee, and seek approval from the Clinical Integration Committee.										
Task Step 4…Utilize the information in Steps 1-3 to present to the Workforce Committee for review & inform the Workforce budget for staff training.										
Task Step 5... Train staff using approved training modules and document attendance in training.										
Milestone #8 Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.										
Task Preventive care screenings implemented among participating PCPs, including behavioral health screenings (PHQ-2 or 9, SBIRT).	29	36	36	36	36	36	36	36	36	36
Task Protocols and processes for referral to appropriate services are in place.										
Task Step 1…Survey partners to identify partners currently utilizing preventive care screening protocols, including behavioral health, to identify current best practices.										
Task Step 2…Discuss clinical best practices with bordering PPS's to align clinical practices to ensure provider continuity.										
Task Step 3…Present Step 1 best practices to the PCMH clinical sub-committee for review & recommendations for PPS sponsored best practices for practice implementation during PCMH site certification.										
Task Step 4…Create a communication & implementation schedule of the best practices identified in Step 2 for all practice sites.										
Task Step 5…Identify staff training needs associated with new or existing best practice protocols; create a training schedule &										

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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
inform the Workforce budget of training needs.										
Task Step 6…Create a quarterly reporting expectation of all partners to identify use of measure on allocated patients, practice needs, or trends.										
Milestone #9 Implement open access scheduling in all primary care practices.										
Task PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.	29	36	36	36	36	36	36	36	36	36
Task PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.	29	36	36	36	36	36	36	36	36	36
Task PPS monitors and decreases no-show rate by at least 15%.	29	36	36	36	36	36	36	36	36	36
Task Step 1…Utilize previously completed surveys or complete needed surveys to identify the current use of open access scheduling; identify implementation gaps.										
Task Step 2…Define open access PPS operational expectations/best practice, present to the clinical sub-committee and seek approval of the Clinical Integration Committee.										
Task Step 3…Communicate PPS best practice to PPS partners with a defined timing expectation of implementation.										
Task Step 4…PMO staff to work with PPS partners to implement process and provide an ongoing resource for education, process questions, or communication channels.										
Task Step 5... PMO to collect feedback & data from PPS partners on open scheduling process- data points will potentially include information on patient experience, wait time, no show rates										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	
Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.	
Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.	
Ensure all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	
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.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.	
Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.	Task 5 end date was changed to 3/31/16 to align with the workforce reporting expectations
Implement open access scheduling in all primary care practices.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	

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IPQR Module 2.a.ii.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 2.a.ii.5 - IA Monitoring

Instructions :

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Project 2.b.v – Care transitions intervention for skilled nursing facility (SNF) residents

IPQR Module 2.b.v.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.

Risk #1: Requirement that partners engage with Medicaid Managed Care Organizations to develop standardized protocols that will include covered services as this PPS is utilizing a collaborative contracting model for the Governance structure.

Mitigation #1: The risk will be mitigated by using the PPS project participants to determine best practices and develop a standardized care transition plan for engaged patients within the PPS. Partners will be able to leverage this approach when negotiating with the MCOs.

Risk #2: Recognizing the learning curve for members of the care transition teams that will manage this project and the subsequent overlapping projects.

Mitigation #2: Specifically for this project, NYHQ will adapt an incremental approach to care transitions focusing on the current workforce and possible pilot program to switch established case managers to care transition teams to ensure a smooth integration of roles and responsibilities. This component of the project will need to align with the Workforce Plan the recruitment, retention and training of care transition coaches. This project must also be linked with the Cultural Competency / Health Literacy implementation plan to increase awareness of transition coaches to the intricacies of the patient population in a culturally-sensitive manner.

Risk #3: The necessity of an inter-operable EHR system is a risk for this project. The PPS has committed to engaging patients beginning DY1 Q2, but the inter-operable EHR system will not be implemented in that time frame. This is a risk as the project requires that that SNFs have access to the patient record and hospital staff prior to discharge to ensure that that the patient is transitioned appropriately.

Mitigation #3: This risk will be mitigated by implementing interim care transition solutions until the EHR system is installed in the PPS.

Risk #4: Individual partner operational processes being inconsistent and allowing for delayed discharges of patients.

Mitigation #4: The PPS clinical teams will focus to improve clinical workflows that focus to care coordination, staff education, communication and timing of discharges to ensure timely planning & communication of discharged patients.

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IPQR Module 2.b.v.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	1,865

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
1,041	1,711	161.11%	-649	91.74%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cc599179	Documentation/Certification	40_PMDL3015_1_3_20160202154126_NYPQ_Care_Transitions_2.b.v.xlsx	Care Transitions 2.b.v engaged patients	02/02/2016 03:41 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 2.b.v.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Partner with associated SNFs to develop a standardized protocol to assist with resolution of the identified issues.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Partnership agreements are in place between hospitals and SNFs and include agreements to coordinate post-admission care.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task SNFs and hospitals have developed care transition policies and procedures, including coordination of thorough and accurate post-admission medical records; ongoing meetings are held to evaluate and improve process.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize previously completed partner survey to identify current state of Transition protocols and practice.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Utilize the NYS Transitions of Care form as the standardized form to distribute to the PPS partners for feedback pertaining to workflows. Document needed updates & create a best practice for the PPS.	Project		In Progress	08/01/2015	01/31/2016	08/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Step 3… Present best practice to the Clinical Integration & Quality Committee for approval.	Project		Not Started	01/31/2016	03/31/2016	01/31/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4… Publish and distribute best practice and expectations of the partners.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5… Implement the PPS best practice utilizing the PMO clinical staff as an implementation resource.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 6…Update IT platforms to ensuring formatting of the updated & approved best practice form.									
Task Step 7… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.	Project		Not Started	07/01/2016	11/01/2016	07/01/2016	11/01/2016	12/31/2016	DY2 Q3
Task Step 8.. Report quarterly to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.	Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Managed Long Term Care or FIDA Plans associated with their identified population to develop transition of care protocols, ensure covered services including DME will be readily available, and that there is a payment strategy for the transition of care services.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged with Medicaid Managed Care and Managed Long Term Care or FIDA plans to develop coordination of care and care transition strategies; PPS has developed agreements and protocols to provide post-admission transition of care services.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Covered services, including Durable Medical Equipment, are available for the identified population.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care and Managed Long Term Care or FIDA Plans.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Engage the PPS legal team to identify boundaries of discussion & engagement to ensure information discussed or shared is compliant with regulations.	Project		In Progress	10/01/2015	02/01/2016	10/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 2…Identify the top payers associated with long-term-care and the PPS partner providers.	Project		In Progress	10/01/2015	01/01/2016	10/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 3…Align the PPS best practice expectation with the MCO/FIDA coverage policies to identify gaps of non-covered services or underfunded services.									
Task Step 4…Create a recommendation of coverage change to include quality based indicators to show improvement potentials and rationale for change. Submit recommendation to the Clinical Integration & Finance Committee to define next steps of negotiations.	Project		Not Started	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5…Invite MCO/FIDA representatives of the top payers to attend a clinical sub-committee to educate the team on their product & outline territory or lives covered.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #3 Develop transition of care protocols that will include timely notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. Ensure that all relevant protocols allow patients in end-of-life situations to transition home with all appropriate services.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Nursing Home	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows SNF staff access to visit patients in the hospital and participate in care transition planning.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Host clinical sub-committee meetings to include all partners to discuss protocols & project progress.	Project		Completed	07/01/2015	03/31/2017	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2…Identify existing best practice protocols or the need for new protocols for planned discharges / transition of care, planned discharges, and the on-site ability for SNF patient visitations; present to clinical sub-committee for review, revision, & recommendation for PPS wide best practice expectation. Tool	Project		Completed	07/01/2015	10/31/2015	07/01/2015	10/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
use will be identified in protocols to include eMOLST, & Cureatr Secure Text Messaging.									
Task Step 3…Present best practice expectations to the Clinical sub-committee for review, revision, recommendations and approvals.	Project		In Progress	11/01/2015	01/31/2016	11/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Step 4…Publish & distribute best practice expectations to all partners.	Project		Not Started	02/01/2016	04/30/2016	02/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task Step 5…PPS leaders to utilize PPS best practice expectations identified to inform provider agreements.	Project		Not Started	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 6…Educate PPS partners and provide opportunities for use of an IT Tool for discharges (Care Manager / Curator).	Project		In Progress	11/01/2015	02/29/2016	11/01/2015	02/29/2016	03/31/2016	DY1 Q4
Task Step 7…Create performance reporting expectations on all best practice expectations approved by the Clinical Integration Committee to include tools, timing, and accountability.	Project		In Progress	11/01/2015	02/29/2016	11/01/2015	02/29/2016	03/31/2016	DY1 Q4
Task Step 8…Provide quarterly quality based performance reports to the clinical sub-committee and the Clinical Integration Committee to identify improvements or additional needs of changes; All changes will be presented to the Clinical Integration Committee for approvals.	Project		Not Started	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Establish protocols for standardized care record transitions to the SNF staff and medical personnel.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinical Interoperability System is in place for all participating providers.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Survey partners to identify current clinical practices & tools utilized for care record transitions. (EHR Direct Messaging & HIE-Healthix)	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Review current clinical practices for record transition; Discuss needs of improvement; Recommend PPS wide protocol	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	02/29/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
for the standardization of care record transition utilizing a clinical interoperable system.									
Task Step 3…Present protocol recommendation to include IT usage & plan to the Clinical Integration Committee for review & approval.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4… Implement the PPS best practice utilizing the PMO clinical nursing staff as a implementation resource.	Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task Step 5… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability	Project		Not Started	09/01/2016	12/31/2016	09/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6.. Quarterly reports will be provided to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure all participating hospitals and SNFs have shared EHR system capability and HIE/RHIO/SHIN-NY access for electronic transition of medical records by the end of DSRIP Year 3.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Survey all partners to establish current IT state to include EHR usage, and RHIO access.(EHR Direct Messaging & HIE-Healthix)	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Identify gaps of electronic health record use or RHIO involvement from the survey and discuss needs with PPS partners.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Create a roll-out schedule for those committed SNF's / hospitals identified in the gap assessment to move to an EHR or	Project		In Progress	10/01/2015	01/31/2016	10/01/2015	01/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
RHIO use for access to electronic health records.									
Task Step 4…Present the roll-out schedule to the IT Committee for review & final recommendation for approval to the Clinical Integration Committee for the initiation of implementation.	Project		Not Started	02/01/2016	05/01/2016	02/01/2016	05/01/2016	06/30/2016	DY2 Q1
Task Step 5…Include the roll-out schedule in Performance Logic (PMO Tool) to outline timing & expectations for progress to be tracked & input by partners. Information will be used for progress reports and PPS dashboards to ensure timely completion.	Project		Not Started	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security. (Allscripts Care Director, Event Notification (Cureatr/Healthix))	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Document processes(s) by partner of tracking engaged patients.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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 Partner with associated SNFs to develop a standardized protocol to assist with resolution of the identified issues.										
Task Partnership agreements are in place between hospitals and SNFs and include agreements to coordinate post-admission care.										
Task SNFs and hospitals have developed care transition policies and procedures, including coordination of thorough and accurate post-admission medical records; ongoing meetings are held to evaluate and improve process.										
Task Step 1…Utilize previously completed partner survey to identify current state of Transition protocols and practice.										
Task Step 2…Utilize the NYS Transitions of Care form as the standardized form to distribute to the PPS partners for feedback pertaining to workflows. Document needed updates & create a best practice for the PPS.										
Task Step 3… Present best practice to the Clinical Integration & Quality Committee for approval.										
Task Step 4… Publish and distribute best practice and expectations of the partners.										
Task Step 5… Implement the PPS best practice utilizing the PMO clinical staff as an implementation resource.										
Task Step 6…Update IT platforms to ensuring formatting of the updated & approved best practice form.										
Task Step 7… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.										
Task Step 8.. Report quarterly to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Managed Long Term Care or FIDA Plans associated with their										

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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
identified population to develop transition of care protocols, ensure covered services including DME will be readily available, and that there is a payment strategy for the transition of care services.										
Task PPS has engaged with Medicaid Managed Care and Managed Long Term Care or FIDA plans to develop coordination of care and care transition strategies; PPS has developed agreements and protocols to provide post-admission transition of care services.										
Task Covered services, including Durable Medical Equipment, are available for the identified population.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care and Managed Long Term Care or FIDA Plans.										
Task Step 1…Engage the PPS legal team to identify boundaries of discussion & engagement to ensure information discussed or shared is compliant with regulations.										
Task Step 2…Identify the top payers associated with long-term-care and the PPS partner providers.										
Task Step 3…Align the PPS best practice expectation with the MCO/FIDA coverage policies to identify gaps of non-covered services or underfunded services.										
Task Step 4…Create a recommendation of coverage change to include quality based indicators to show improvement potentials and rationale for change. Submit recommendation to the Clinical Integration & Finance Committee to define next steps of negotiations.										
Task Step 5…Invite MCO/FIDA representatives of the top payers to attend a clinical sub-committee to educate the team on their product & outline territory or lives covered.										
Milestone #3 Develop transition of care protocols that will include timely notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. Ensure that all relevant protocols allow patients in end-of-life situations to transition home with all										

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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
appropriate services.										
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	12	27	47	70	97	97	97
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	3	8	13	19	27	27	27
Task PPS has program in place that allows SNF staff access to visit patients in the hospital and participate in care transition planning.										
Task Step 1…Host clinical sub-committee meetings to include all partners to discuss protocols & project progress.										
Task Step 2…Identify existing best practice protocols or the need for new protocols for planned discharges / transition of care, planned discharges, and the on-site ability for SNF patient visitations; present to clinical sub-committee for review, revision, & recommendation for PPS wide best practice expectation. Tool use will be identified in protocols to include eMOLST, & Cureatr Secure Text Messaging.										
Task Step 3…Present best practice expectations to the Clinical sub-committee for review, revision, recommendations and approvals.										
Task Step 4…Publish & distribute best practice expectations to all partners.										
Task Step 5…PPS leaders to utilize PPS best practice expectations identified to inform provider agreements.										
Task Step 6…Educate PPS partners and provide opportunities for use of an IT Tool for discharges (Care Manager / Curator).										
Task Step 7…Create performance reporting expectations on all best practice expectations approved by the Clinical Integration Committee to include tools, timing, and accountability.										
Task Step 8…Provide quarterly quality based performance reports to the clinical sub-committee and the Clinical Integration Committee to identify improvements or additional needs of changes; All changes will be presented to the Clinical Integration Committee										

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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
for approvals.										
Milestone #4 Establish protocols for standardized care record transitions to the SNF staff and medical personnel.										
Task Clinical Interoperability System is in place for all participating providers.										
Task Step 1…Survey partners to identify current clinical practices & tools utilized for care record transitions. (EHR Direct Messaging & HIE-Healthix)										
Task Step 2…Review current clinical practices for record transition; Discuss needs of improvement; Recommend PPS wide protocol for the standardization of care record transition utilizing a clinical interoperable system.										
Task Step 3…Present protocol recommendation to include IT usage & plan to the Clinical Integration Committee for review & approval.										
Task Step 4… Implement the PPS best practice utilizing the PMO clinical nursing staff as a implementation resource.										
Task Step 5… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability										
Task Step 6.. Quarterly reports will be provided to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval										
Milestone #5 Ensure all participating hospitals and SNFs have shared EHR system capability and HIE/RHIO/SHIN-NY access for electronic transition of medical records by the end of DSRIP Year 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	6	18	24	30	34	34	34
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	3	8	13	19	27	27	27
Task Step 1…Survey all partners to establish current IT state to										

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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
include EHR usage, and RHIO access.(EHR Direct Messaging & HIE-Healthix)										
Task Step 2…Identify gaps of electronic health record use or RHIO involvement from the survey and discuss needs with PPS partners.										
Task Step 3…Create a roll-out schedule for those committed SNF's / hospitals identified in the gap assessment to move to an EHR or RHIO use for access to electronic health records.										
Task Step 4…Present the roll-out schedule to the IT Committee for review & final recommendation for approval to the Clinical Integration Committee for the initiation of implementation.										
Task Step 5…Include the roll-out schedule in Performance Logic (PMO Tool) to outline timing & expectations for progress to be tracked & input by partners. Information will be used for progress reports and PPS dashboards to ensure timely completion.										
Milestone #6 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security. (Allscripts Care Director, Event Notification (Cureatr/Healthix))										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document processes(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding										

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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
volume/performance.										

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
Milestone #1 Partner with associated SNFs to develop a standardized protocol to assist with resolution of the identified issues.										
Task Partnership agreements are in place between hospitals and SNFs and include agreements to coordinate post-admission care.										
Task SNFs and hospitals have developed care transition policies and procedures, including coordination of thorough and accurate post-admission medical records; ongoing meetings are held to evaluate and improve process.										
Task Step 1…Utilize previously completed partner survey to identify current state of Transition protocols and practice.										
Task Step 2…Utilize the NYS Transitions of Care form as the standardized form to distribute to the PPS partners for feedback pertaining to workflows. Document needed updates & create a best practice for the PPS.										
Task Step 3… Present best practice to the Clinical Integration & Quality Committee for approval.										
Task Step 4… Publish and distribute best practice and expectations of the partners.										
Task Step 5… Implement the PPS best practice utilizing the PMO clinical staff as an implementation resource.										
Task Step 6…Update IT platforms to ensuring formatting of the updated & approved best practice form.										
Task Step 7… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.										
Task Step 8.. Report quarterly to the clinical sub-committee for reviews										

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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
of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Managed Long Term Care or FIDA Plans associated with their identified population to develop transition of care protocols, ensure covered services including DME will be readily available, and that there is a payment strategy for the transition of care services.										
Task PPS has engaged with Medicaid Managed Care and Managed Long Term Care or FIDA plans to develop coordination of care and care transition strategies; PPS has developed agreements and protocols to provide post-admission transition of care services.										
Task Covered services, including Durable Medical Equipment, are available for the identified population.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care and Managed Long Term Care or FIDA Plans.										
Task Step 1…Engage the PPS legal team to identify boundaries of discussion & engagement to ensure information discussed or shared is compliant with regulations.										
Task Step 2…Identify the top payers associated with long-term-care and the PPS partner providers.										
Task Step 3…Align the PPS best practice expectation with the MCO/FIDA coverage policies to identify gaps of non-covered services or underfunded services.										
Task Step 4…Create a recommendation of coverage change to include quality based indicators to show improvement potentials and rationale for change. Submit recommendation to the Clinical Integration & Finance Committee to define next steps of negotiations.										
Task Step 5…Invite MCO/FIDA representatives of the top payers to attend a clinical sub-committee to educate the team on their product & outline territory or lives covered.										

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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
Milestone #3 Develop transition of care protocols that will include timely notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. Ensure that all relevant protocols allow patients in end-of-life situations to transition home with all appropriate services.										
Task Policies and procedures are in place for early notification of planned discharges.	97	97	97	97	97	97	97	97	97	97
Task Policies and procedures are in place for early notification of planned discharges.	27	27	27	27	27	27	27	27	27	27
Task PPS has program in place that allows SNF staff access to visit patients in the hospital and participate in care transition planning.										
Task Step 1…Host clinical sub-committee meetings to include all partners to discuss protocols & project progress.										
Task Step 2…Identify existing best practice protocols or the need for new protocols for planned discharges / transition of care, planned discharges, and the on-site ability for SNF patient visitations; present to clinical sub-committee for review, revision, & recommendation for PPS wide best practice expectation. Tool use will be identified in protocols to include eMOLST, & Cureatr Secure Text Messaging.										
Task Step 3…Present best practice expectations to the Clinical sub-committee for review, revision, recommendations and approvals.										
Task Step 4…Publish & distribute best practice expectations to all partners.										
Task Step 5…PPS leaders to utilize PPS best practice expectations identified to inform provider agreements.										
Task Step 6…Educate PPS partners and provide opportunities for use of an IT Tool for discharges (Care Manager / Curator).										
Task Step 7…Create performance reporting expectations on all best practice expectations approved by the Clinical Integration Committee to include tools, timing, and accountability.										

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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 Step 8…Provide quarterly quality based performance reports to the clinical sub-committee and the Clinical Integration Committee to identify improvements or additional needs of changes; All changes will be presented to the Clinical Integration Committee for approvals.										
Milestone #4 Establish protocols for standardized care record transitions to the SNF staff and medical personnel.										
Task Clinical Interoperability System is in place for all participating providers.										
Task Step 1…Survey partners to identify current clinical practices & tools utilized for care record transitions. (EHR Direct Messaging & HIE-Healthix)										
Task Step 2…Review current clinical practices for record transition; Discuss needs of improvement; Recommend PPS wide protocol for the standardization of care record transition utilizing a clinical interoperable system.										
Task Step 3…Present protocol recommendation to include IT usage & plan to the Clinical Integration Committee for review & approval.										
Task Step 4… Implement the PPS best practice utilizing the PMO clinical nursing staff as a implementation resource.										
Task Step 5… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability										
Task Step 6.. Quarterly reports will be provided to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval										
Milestone #5 Ensure all participating hospitals and SNFs have shared EHR system capability and HIE/RHIO/SHIN-NY access for electronic transition of medical records by the end of DSRIP Year 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	34	34	34	34	34	34	34	34	34	34

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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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	27	27	27	27	27	27	27	27	27	27
Task Step 1…Survey all partners to establish current IT state to include EHR usage, and RHIO access.(EHR Direct Messaging & HIE-Healthix)										
Task Step 2…Identify gaps of electronic health record use or RHIO involvement from the survey and discuss needs with PPS partners.										
Task Step 3…Create a roll-out schedule for those committed SNF's / hospitals identified in the gap assessment to move to an EHR or RHIO use for access to electronic health records.										
Task Step 4…Present the roll-out schedule to the IT Committee for review & final recommendation for approval to the Clinical Integration Committee for the initiation of implementation.										
Task Step 5…Include the roll-out schedule in Performance Logic (PMO Tool) to outline timing & expectations for progress to be tracked & input by partners. Information will be used for progress reports and PPS dashboards to ensure timely completion.										
Milestone #6 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security. (Allscripts Care Director, Event Notification (Cureatr/Healthix))										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task										

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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
Step 4…Document processes(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Partner with associated SNFs to develop a standardized protocol to assist with resolution of the identified issues.	
Engage with the Medicaid Managed Care Organizations and Managed Long Term Care or FIDA Plans associated with their identified population to develop transition of care protocols, ensure covered services including DME will be readily available, and that there is a payment strategy for the transition of care services.	
Develop transition of care protocols that will include timely notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. Ensure that all relevant protocols allow patients in end-of-life situations to transition home with all appropriate services.	
Establish protocols for standardized care record transitions to the SNF staff and medical personnel.	Task 2 end date changed to 2/29/16 as clinical sub-committee is continuing to review and define the record transition process for the project
Ensure all participating hospitals and SNFs have shared EHR system capability and HIE/RHIO/SHIN-NY access for electronic transition of medical records by the end of DSRIP Year 3.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	

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IPQR Module 2.b.v.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 2.b.v.5 - IA Monitoring

Instructions :

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Project 2.b.vii – Implementing the INTERACT project (inpatient transfer avoidance program for SNF)

IPQR Module 2.b.vii.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.

Risk #1: The engagement of practitioners and staff. This project requires that physician champions be nominated and that coaching programs be utilized to train staff throughout the PPS. In order for these mechanisms to be successful, staff and practitioners must be engaged in DSRIP and the implementation of INTERACT.

Mitigation #1: The PPS will mitigate this risk by having a strong, enthusiastic project committee which will pave the way for practitioner engagement and project implementation. The project committee will also partner with the practitioner engagement committee as needed to ensure that information is disseminated in a timely fashion to the PPS members and encourage engagement and a results oriented system for the DSRIP projects.

Risk #2: Maximizing day to day requirements of front end staff while integrating training that is needed to become proficient and comfortable to support the implementation.

Mitigation #2: Strategies will contain best practice methods and recruitment to identify champions to motivate, educate and engage among peers. Caregiver training on the components of the INTERTACT need to be recognized at the PPS level as well as at the administrative employer level so that the staff can be supported. Train the trainer options needs to be pursued to maximize training opportunities and change behavior tactics integrated early in the process to enhance acceptance and ownership. The immediate positive outcome to the INTERACT project is that once staff acceptance is recognized and staff become vested in the project, the level of care and positive outcomes will help to drive the project. Staff will recognize their impact, start to explore new ideas and concepts that can be adapted to the current state, and commit to improving patient outcomes.

Risk #3: The varying levels of EHR systems and interoperability currently implemented across PPS partners. As the PPS moves forward with DSRIP, the goal is to bring all PPS partners up to the same EHR standard and create an interoperable EHR system.

Mitigation #3: The INTERACT tool is available in numerous forms i.e.: electronic, paper etc. This will allow partners to implement the tool immediately and then adapt moving forward once the IT systems are upgraded.

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IPQR Module 2.b.vii.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	1,765

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
291	481	60.58%	313	27.25%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (794)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cc599179	Documentation/Certification	40_PMDL3215_1_3_20160202154440_NYPQ_INTERACT_2.b.vii.xlsx	INTERACT 2.b.vii engaged patients	02/02/2016 03:45 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 2.b.vii.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT principles implemented at each participating SNF.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Nursing home to hospital transfers reduced.	Provider	Nursing Home	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT 3.0 Toolkit used at each SNF.	Provider	Nursing Home	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Survey partners to identify current clinical state & use of INTERACT or INTERACT like principles.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Identify partners currently not utilizing INTERACT & create an action plan with timing for implementation.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Present educational sessions at the clinical sub-committee on INTERACT principles, implementation of INTERACT, or success stories of INTERACT for partners currently not utilizing or utilizing to the max capacity at the clinical sub-committee meetings.	Project		In Progress	10/01/2015	01/01/2016	10/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 4…Establish baseline hospital transfer rates for all SNF's; publish & communicate to the clinical sub-committee. Compare rates to national or local standards, identify outliers, and engage clinical sub-committee for discussions to begin improvements.	Project		In Progress	10/01/2015	02/01/2016	10/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 5…Create a timeline to include all partners for the implementation of INTERACT that aligns with the project	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
requirement end date of DY2, Q4.									
Task Step 6…Create a PPS educational opportunity for staff & providers for INTERACT with a train the trainer style to ensure ongoing education.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 7…Implement the INTERACT partner implementation timeline into Performance Logic for progress tracking by partners.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 8…Utilize PMO clinical staff and existing best practice organizations to be a resource for implementation or knowledge source for implementation or ongoing support.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Project	N/A	In Progress	07/01/2015	02/01/2016	07/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Facility champion identified for each SNF.	Provider	Nursing Home	In Progress	07/01/2015	02/01/2016	07/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 1…Survey partners to identify any existing facility champions or providers with the skillset and ability to become a champion.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Identify core expectations & ongoing educational expectations of a 'facility champion' and submit to the clinical sub-committee for review & recommendation to the Clinical Integration Committee for approval.	Project		Completed	07/01/2015	10/01/2015	07/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task Step 3…Identify a facility champion, based on the survey, and present to the clinical sub-committee for review & recommendation to the Clinical Integration Committee for approval.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 4…Extend invite of all clinical sub-committee meetings to all facility champions in order to allow for networking, education, or progress updates.	Project		Not Started	01/01/2016	02/01/2016	01/01/2016	02/01/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	10/01/2015	01/01/2016	10/01/2015	01/01/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 5…Establish an expectation of the PMO clinical staff to check-in quarterly with each clinical champion to identify trends, issues, or needs of the programs.									
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Project	N/A	In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize existing best practices of partner organizations to identify options for care pathways or tools focused to early identification to avoid hospital transfers; Present options to the clinical sub-committee for review & revisions. (IT Tool: Allscripts Care Director)	Project		Completed	08/01/2015	10/01/2015	08/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task Step 2…Present recommendation of a PPS wide best practice standard to the Clinical Integration Committee for review, revision, and approval.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…Publish and communicate the approved PPS wide best practice standard to all partners with an expectation of timing for implementation as well as staff training & ongoing training.	Project		In Progress	12/01/2015	02/01/2016	12/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 4…Establish a performance reporting process to track implementation, progress, and impact of changes by location.	Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5…Report progress to the clinical sub-committee quarterly to review findings & plan any needed changes.	Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Educate all staff on care pathways and INTERACT principles.	Project	N/A	In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Provider	Nursing Home	In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Training program for all SNF staff established encompassing care pathways and INTERACT principles.									
Task Step 1…Identify training needs by partner based on staffing levels, historic use of INTERACT, or unmet training needs (all sites).	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Utilize existing resources or subject matter experts to create basic training expectations identified by categories of staff.	Project		Completed	09/01/2015	12/01/2015	09/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…Use the clinical sub-committee to review/revise training plan.	Project		In Progress	12/01/2015	02/01/2016	12/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 4…Communicate training expectations to all partners committed to the INTERACT project. Provide additional training as needed on care pathways and INTERACT principles for staff members.	Project		Not Started	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5…Load training expectations into Performance Logic for monthly partner updates of progress.	Project		Not Started	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Identify industry or partner best practices for Advance Care Planning tools and present for discussion & planning by the clinical sub-committee.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Engage the Palliative Care clinical sub-committee chair to review & revise proposed best practices for Advance Care Planning Tools.	Project		Completed	07/01/2015	12/01/2015	07/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 3…Ensure engagement of physicians by presenting tools at designated partner physician meetings or leadership. Allow for input.									
Task Step 4…Present proposal of Advance Care Planning tools to be used PPS-wide to the Clinical Integration Committee for approval.	Project		In Progress	10/01/2015	01/01/2016	10/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 5…Publish & communicate the plan approved to all partners with expectations of timing for roll-out.	Project		Not Started	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task Step 6…Create a reporting process to the PMO clinical staff for implementation of the tools as well as feedback on utilization for ongoing updates to ensure process improvements.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7... Load training and reporting expectations into Performance Logic	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Create coaching program to facilitate and support implementation.	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT coaching program established at each SNF.	Provider	Nursing Home	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Create an coaching program outline and present to the clinical sub-committee for review & revisions.	Project		Not Started	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1
Task Step 2…Allow existing facilities utilizing INTERACT to review coaching program proposals for review & revisions.	Project		Not Started	03/01/2016	05/01/2016	03/01/2016	05/01/2016	06/30/2016	DY2 Q1
Task Step 3…Publish and communicate the coaching program with a partner schedule for training that is flexible to partner/staff/provider needs.	Project		Not Started	05/01/2016	07/01/2016	05/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 4…Input training schedule into Performance Logic (PMO Tool) to establish expectations of timing & deliverables.	Project		Not Started	05/01/2016	03/31/2017	05/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Patients and families educated and involved in planning of care using INTERACT principles.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Identify existing patient/family/caretaker educational programs housed at facilities or performed by CBO's.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Use existing SME's or best practices to inform a PPS foundation of education for patients/family/caretakers; Present to clinical sub-committee for review & revisions.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Invite CBO's with this expertise to review program and provide input and recommendations for use of the CBO.	Project		Completed	07/01/2015	10/01/2015	07/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task Step 4…Publish & communicate educational program to the committed partners involved.	Project		Not Started	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task Step 5…Contract with CBO's for educational opportunities identified in this requirement.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 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		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize the IT survey outlined in the Organization Implementation Plan to identify partners with no EHR or EHR's that do not meet Meaning Use expectations. (EHR Direct Messaging, HIE-Healthix, Cureatr Secure Text Messaging)	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 2…Follow the plan outlined in the IT Implementation Plan to identify a roadmap & timing to close the gap for non-EHR use or MU inadequacies.									
Task Step 3…Provide ongoing feedback to the clinical sub-committee regarding connectivity or issues identified.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Service and quality outcome measures are reported to all stakeholders.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…As a clinical sub-committee, identify the top clinical indicators that best represent the patient population, program, or process that the INTERACT program will influence.	Project		In Progress	07/01/2015	10/31/2015	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2…Establish baselines, risk adjusted as needed, of clinical indicators identified for all committed partners and compare to national or local industry benchmarks.	Project		In Progress	09/01/2015	11/01/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3…Identify risks associated with indicators as they relate to the requirements of the project to ensure adequate influence on metrics.	Project		In Progress	09/01/2015	11/01/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4…Communicate baseline, benchmark, and risk	Project		Not Started	11/01/2015	12/31/2015	02/01/2016	06/30/2016	06/30/2016	DY2 Q1

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
information to the clinical sub-committee & the Clinical Integration Committee (Quality Committee) for review & feedback.									
Task Step 5…Establish reporting expectations for all indicators utilizing Amalgam Population Health andor Allscripts Care Director Analytics to be reported to the clinical sub-committee and Clinical Integration Committee for review & clinical process recommendations for changes to positively affect individual indicators.	Project		In Progress	10/01/2015	12/01/2015	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6…PMO clinical staff focused to rapid cycle evaluation will become the primary driver of the data to ensure tracking & progress to change. PMO staff will work directly with partners based on the feedback from the Clinical Integration Committee to influence change.	Project		Not Started	11/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7... Load expectations for measuring outcomes into Performance Logic	Project		Not Started	11/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.	Project		Completed	07/01/2015	09/15/2015	07/01/2015	09/15/2015	09/30/2015	DY1 Q2
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Document process(s) by partner of tracking engaged	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patients.									
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.	Project		Completed	07/01/2015	03/31/2017	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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 INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	0	0	0	3	8	13	19	27	27	27
Task INTERACT 3.0 Toolkit used at each SNF.	0	0	0	3	8	13	19	27	27	27
Task Step 1…Survey partners to identify current clinical state & use of INTERACT or INTERACT like principles.										
Task Step 2…Identify partners currently not utilizing INTERACT & create an action plan with timing for implementation.										
Task Step 3…Present educational sessions at the clinical sub-committee on INTERACT principles, implementation of INTERACT, or success stories of INTERACT for partners currently not utilizing or utilizing to the max capacity at the clinical sub-committee meetings.										
Task Step 4…Establish baseline hospital transfer rates for all SNF's; publish & communicate to the clinical sub-committee. Compare rates to national or local standards, identify outliers, and engage clinical sub-committee for discussions to begin improvements.										
Task Step 5…Create a timeline to include all partners for the implementation of INTERACT that aligns with the project requirement end date of DY2, Q4.										
Task										

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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
Step 6…Create a PPS educational opportunity for staff & providers for INTERACT with a train the trainer style to ensure ongoing education.										
Task Step 7…Implement the INTERACT partner implementation timeline into Performance Logic for progress tracking by partners.										
Task Step 8…Utilize PMO clinical staff and existing best practice organizations to be a resource for implementation or knowledge source for implementation or ongoing support.										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										
Task Facility champion identified for each SNF.	0	0	0	3	8	13	19	27	27	27
Task Step 1…Survey partners to identify any existing facility champions or providers with the skillset and ability to become a champion.										
Task Step 2…Identify core expectations & ongoing educational expectations of a 'facility champion' and submit to the clinical sub-committee for review & recommendation to the Clinical Integration Committee for approval.										
Task Step 3…Identify a facility champion, based on the survey, and present to the clinical sub-committee for review & recommendation to the Clinical Integration Committee for approval.										
Task Step 4…Extend invite of all clinical sub-committee meetings to all facility champions in order to allow for networking, education, or progress updates.										
Task Step 5…Establish an expectation of the PMO clinical staff to check-in quarterly with each clinical champion to identify trends, issues, or needs of the programs.										
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										

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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
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task Step 1…Utilize existing best practices of partner organizations to identify options for care pathways or tools focused to early identification to avoid hospital transfers; Present options to the clinical sub-committee for review & revisions. (IT Tool: Allscripts Care Director)										
Task Step 2…Present recommendation of a PPS wide best practice standard to the Clinical Integration Committee for review, revision, and approval.										
Task Step 3…Publish and communicate the approved PPS wide best practice standard to all partners with an expectation of timing for implementation as well as staff training & ongoing training.										
Task Step 4…Establish a performance reporting process to track implementation, progress, and impact of changes by location.										
Task Step 5…Report progress to the clinical sub-committee quarterly to review findings & plan any needed changes.										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	0	0	0	3	8	13	19	27	27	27
Task Step 1…Identify training needs by partner based on staffing levels, historic use of INTERACT, or unmet training needs (all sites).										
Task Step 2…Utilize existing resources or subject matter experts to create basic training expectations identified by categories of staff.										
Task Step 3…Use the clinical sub-committee to review/revise training plan.										

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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
Task Step 4…Communicate training expectations to all partners committed to the INTERACT project. Provide additional training as needed on care pathways and INTERACT principles for staff members.										
Task Step 5…Load training expectations into Performance Logic for monthly partner updates of progress.										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task Step 1…Identify industry or partner best practices for Advance Care Planning tools and present for discussion & planning by the clinical sub-committee.										
Task Step 2…Engage the Palliative Care clinical sub-committee chair to review & revise proposed best practices for Advance Care Planning Tools.										
Task Step 3…Ensure engagement of physicians by presenting tools at designated partner physician meetings or leadership. Allow for input.										
Task Step 4…Present proposal of Advance Care Planning tools to be used PPS-wide to the Clinical Integration Committee for approval.										
Task Step 5…Publish & communicate the plan approved to all partners with expectations of timing for roll-out.										
Task Step 6…Create a reporting process to the PMO clinical staff for implementation of the tools as well as feedback on utilization for ongoing updates to ensure process improvements.										
Task Step 7... Load training and reporting expectations into Performance Logic										
Milestone #6 Create coaching program to facilitate and support										

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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
implementation.										
Task INTERACT coaching program established at each SNF.	0	0	0	3	8	13	19	27	27	27
Task Step 1…Create an coaching program outline and present to the clinical sub-committee for review & revisions.										
Task Step 2…Allow existing facilities utilizing INTERACT to review coaching program proposals for review & revisions.										
Task Step 3…Publish and communicate the coaching program with a partner schedule for training that is flexible to partner/staff/provider needs.										
Task Step 4…Input training schedule into Performance Logic (PMO Tool) to establish expectations of timing & deliverables.										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										
Task Step 1…Identify existing patient/family/caretaker educational programs housed at facilities or performed by CBO's.										
Task Step 2…Use existing SME's or best practices to inform a PPS foundation of education for patients/family/caretakers; Present to clinical sub-committee for review & revisions.										
Task Step 3…Invite CBO's with this expertise to review program and provide input and recommendations for use of the CBO.										
Task Step 4…Publish & communicate educational program to the committed partners involved.										
Task Step 5…Contract with CBO's for educational opportunities identified in this requirement.										
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.										

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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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	1	1	1
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	3	8	13	19	27	27	27
Task Step 1…Utilize the IT survey outlined in the Organization Implementation Plan to identify partners with no EHR or EHR's that do not meet Meaning Use expectations. (EHR Direct Messaging, HIE-Healthix, Cureatr Secure Text Messaging)										
Task Step 2…Follow the plan outlined in the IT Implementation Plan to identify a roadmap & timing to close the gap for non-EHR use or MU inadequacies.										
Task Step 3…Provide ongoing feedback to the clinical sub-committee regarding connectivity or issues identified.										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1…As a clinical sub-committee, identify the top clinical indicators that best represent the patient population, program, or process that the INTERACT program will influence.										

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Task Step 2…Establish baselines, risk adjusted as needed, of clinical indicators identified for all committed partners and compare to national or local industry benchmarks.										
Task Step 3…Identify risks associated with indicators as they relate to the requirements of the project to ensure adequate influence on metrics.										
Task Step 4…Communicate baseline, benchmark, and risk information to the clinical sub-committee & the Clinical Integration Committee (Quality Committee) for review & feedback.										
Task Step 5…Establish reporting expectations for all indicators utilizing Amalgam Population Health andor Allscripts Care Director Analytics to be reported to the clinical sub-committee and Clinical Integration Committee for review & clinical process recommendations for changes to positively affect individual indicators.										
Task Step 6…PMO clinical staff focused to rapid cycle evaluation will become the primary driver of the data to ensure tracking & progress to change. PMO staff will work directly with partners based on the feedback from the Clinical Integration Committee to influence change.										
Task Step 7... Load expectations for measuring outcomes into Performance Logic										
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task										

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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
Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										

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
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	27	27	27	27	27	27	27	27	27	27
Task INTERACT 3.0 Toolkit used at each SNF.	27	27	27	27	27	27	27	27	27	27
Task Step 1…Survey partners to identify current clinical state & use of INTERACT or INTERACT like principles.										
Task Step 2…Identify partners currently not utilizing INTERACT & create an action plan with timing for implementation.										
Task Step 3…Present educational sessions at the clinical sub-committee on INTERACT principles, implementation of INTERACT, or success stories of INTERACT for partners currently not utilizing or utilizing to the max capacity at the clinical sub-committee meetings.										
Task Step 4…Establish baseline hospital transfer rates for all SNF's; publish & communicate to the clinical sub-committee. Compare rates to national or local standards, identify outliers, and engage clinical sub-committee for discussions to begin improvements.										
Task Step 5…Create a timeline to include all partners for the implementation of INTERACT that aligns with the project requirement end date of DY2, Q4.										

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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 Step 6…Create a PPS educational opportunity for staff & providers for INTERACT with a train the trainer style to ensure ongoing education.										
Task Step 7…Implement the INTERACT partner implementation timeline into Performance Logic for progress tracking by partners.										
Task Step 8…Utilize PMO clinical staff and existing best practice organizations to be a resource for implementation or knowledge source for implementation or ongoing support.										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										
Task Facility champion identified for each SNF.	27	27	27	27	27	27	27	27	27	27
Task Step 1…Survey partners to identify any existing facility champions or providers with the skillset and ability to become a champion.										
Task Step 2…Identify core expectations & ongoing educational expectations of a 'facility champion' and submit to the clinical sub-committee for review & recommendation to the Clinical Integration Committee for approval.										
Task Step 3…Identify a facility champion, based on the survey, and present to the clinical sub-committee for review & recommendation to the Clinical Integration Committee for approval.										
Task Step 4…Extend invite of all clinical sub-committee meetings to all facility champions in order to allow for networking, education, or progress updates.										
Task Step 5…Establish an expectation of the PMO clinical staff to check-in quarterly with each clinical champion to identify trends, issues, or needs of the programs.										
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										

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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 Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task Step 1…Utilize existing best practices of partner organizations to identify options for care pathways or tools focused to early identification to avoid hospital transfers; Present options to the clinical sub-committee for review & revisions. (IT Tool: Allscripts Care Director)										
Task Step 2…Present recommendation of a PPS wide best practice standard to the Clinical Integration Committee for review, revision, and approval.										
Task Step 3…Publish and communicate the approved PPS wide best practice standard to all partners with an expectation of timing for implementation as well as staff training & ongoing training.										
Task Step 4…Establish a performance reporting process to track implementation, progress, and impact of changes by location.										
Task Step 5…Report progress to the clinical sub-committee quarterly to review findings & plan any needed changes.										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	27	27	27	27	27	27	27	27	27	27
Task Step 1…Identify training needs by partner based on staffing levels, historic use of INTERACT, or unmet training needs (all sites).										
Task Step 2…Utilize existing resources or subject matter experts to create basic training expectations identified by categories of staff.										
Task Step 3…Use the clinical sub-committee to review/revise training plan.										

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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 Step 4…Communicate training expectations to all partners committed to the INTERACT project. Provide additional training as needed on care pathways and INTERACT principles for staff members.										
Task Step 5…Load training expectations into Performance Logic for monthly partner updates of progress.										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task Step 1…Identify industry or partner best practices for Advance Care Planning tools and present for discussion & planning by the clinical sub-committee.										
Task Step 2…Engage the Palliative Care clinical sub-committee chair to review & revise proposed best practices for Advance Care Planning Tools.										
Task Step 3…Ensure engagement of physicians by presenting tools at designated partner physician meetings or leadership. Allow for input.										
Task Step 4…Present proposal of Advance Care Planning tools to be used PPS-wide to the Clinical Integration Committee for approval.										
Task Step 5…Publish & communicate the plan approved to all partners with expectations of timing for roll-out.										
Task Step 6…Create a reporting process to the PMO clinical staff for implementation of the tools as well as feedback on utilization for ongoing updates to ensure process improvements.										
Task Step 7... Load training and reporting expectations into Performance Logic										
Milestone #6 Create coaching program to facilitate and support										

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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
implementation.										
Task INTERACT coaching program established at each SNF.	27	27	27	27	27	27	27	27	27	27
Task Step 1…Create an coaching program outline and present to the clinical sub-committee for review & revisions.										
Task Step 2…Allow existing facilities utilizing INTERACT to review coaching program proposals for review & revisions.										
Task Step 3…Publish and communicate the coaching program with a partner schedule for training that is flexible to partner/staff/provider needs.										
Task Step 4…Input training schedule into Performance Logic (PMO Tool) to establish expectations of timing & deliverables.										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										
Task Step 1…Identify existing patient/family/caretaker educational programs housed at facilities or performed by CBO's.										
Task Step 2…Use existing SME's or best practices to inform a PPS foundation of education for patients/family/caretakers; Present to clinical sub-committee for review & revisions.										
Task Step 3…Invite CBO's with this expertise to review program and provide input and recommendations for use of the CBO.										
Task Step 4…Publish & communicate educational program to the committed partners involved.										
Task Step 5…Contract with CBO's for educational opportunities identified in this requirement.										
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.										

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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 EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	1	1	1	1	1	1	1	1	1	1
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	27	27	27	27	27	27	27	27	27	27
Task Step 1…Utilize the IT survey outlined in the Organization Implementation Plan to identify partners with no EHR or EHR's that do not meet Meaning Use expectations. (EHR Direct Messaging, HIE-Healthix, Cureatr Secure Text Messaging)										
Task Step 2…Follow the plan outlined in the IT Implementation Plan to identify a roadmap & timing to close the gap for non-EHR use or MU inadequacies.										
Task Step 3…Provide ongoing feedback to the clinical sub-committee regarding connectivity or issues identified.										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1…As a clinical sub-committee, identify the top clinical indicators that best represent the patient population, program, or process that the INTERACT program will influence.										

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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 Step 2…Establish baselines, risk adjusted as needed, of clinical indicators identified for all committed partners and compare to national or local industry benchmarks.										
Task Step 3…Identify risks associated with indicators as they relate to the requirements of the project to ensure adequate influence on metrics.										
Task Step 4…Communicate baseline, benchmark, and risk information to the clinical sub-committee & the Clinical Integration Committee (Quality Committee) for review & feedback.										
Task Step 5…Establish reporting expectations for all indicators utilizing Amalgam Population Health andor Allscripts Care Director Analytics to be reported to the clinical sub-committee and Clinical Integration Committee for review & clinical process recommendations for changes to positively affect individual indicators.										
Task Step 6…PMO clinical staff focused to rapid cycle evaluation will become the primary driver of the data to ensure tracking & progress to change. PMO staff will work directly with partners based on the feedback from the Clinical Integration Committee to influence change.										
Task Step 7... Load expectations for measuring outcomes into Performance Logic										
Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task										

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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
Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Task 5 moved to 3/31/16 as clinical committee is in the process of completing the timeline based on the information gathered from partners on current state
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	
Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	
Educate all staff on care pathways and INTERACT principles.	
Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	
Create coaching program to facilitate and support implementation.	
Educate patient and family/caretakers, to facilitate participation in planning of care.	
Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Tasks 1-5 have all been moved to an end date of 6/30/16 to align with the upcoming DOH release of patient roster and performance data and PPS processing and analyzing of the information

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Use EHRs and other technical platforms to track all patients engaged in the project.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	

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IPQR Module 2.b.vii.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 2.b.vii.5 - IA Monitoring

Instructions :

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Project 2.b.viii – Hospital-Home Care Collaboration Solutions

IPQR Module 2.b.viii.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.

Risk #1: The engagement of the patients. In order for this project to be successful, patients need to accept and participate in the home care plan, including Advanced Care Planning, as medically necessary, in transition from the hospital to home care.

Mitigation #1: This risk will be mitigated by utilizing a patient-centric rapid response team to educate the patient/care giver on the benefits of engaging with the home care and advanced care planning, as medically warranted. The home care providers will utilize INTERACT-like principles to duplication of efforts surrounding the .
Risk #2: Home Care providers adoption of an INTERACT like tool
Mitigation #2: NYHQ will secure commitment from the Home Care providers to adopt INTERACT-like tools.

Risk #3: The lack of telehealth infrastructure at participating PPS providers.

Mitigation #3: In order to expand the telehealth infrastructure, several PPS partners requested CRFP funds through the state process. Additionally, the PPS budgeting process will allocate a portion of the DSRIP funds for uncovered services. Both of these funding sources will help to mitigate this risk and ensure this is project requirement is met by the PPS.

Risk #4: Standardization of care pathways with the ability to track utilization and outcomes with EHR/RHIO tools.

Mitigation #4: The IT Committee will partner with the clinical sub-committee to ensure understanding of use as well as gap of needs for IT tools for proper tracking. PPS standardization & expectations will be set by the clinical sub-committee.

Risk #5: Full partner use of the RHIO to maximize access to patient records for care coordination to include pharmacies.

Mitigation #5: Pharmacies will be included in all clinical planning & IT discussions/surveys to ensure understanding of the current state & needs of the program.

Risk #6: The lack of interoperability of IT platforms and tools (INTERACT & INTERACT like) to avoid duplication of workflows and inconsistency of processes.

Mitigation #6: EMR & RHIO tools will be maximized & workflows will be standardized to ensure similarity and focus to outcomes.

Risk #7: Proper tracking of 'engaged patients' utilizing multiple EHR's and partners with no electronic capabilities.

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Mitigation #7: A PPS Population Health Tool will be utilized to track patients (Allscripts) for all partners to focus to consistent tracking & measures.

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IPQR Module 2.b.viii.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	1,205

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
239	476	87.82%	66	39.50%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (542)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cc599179	Documentation/Certification	40_PMDL3315_1_3_20160202155034_NYPQ_Home_Care_2.b.viii.xlsx	Home Care 2.b.viii patient engagement	02/02/2016 03:51 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 2.b.viii.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Project	N/A	In Progress	07/01/2015	03/31/2019	07/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services	Project		In Progress	07/01/2015	03/31/2019	07/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1…Utilize previously completed partner survey to identify current state of discharge protocols and practice.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Identify existing best practices of partner organizations to identify options for care pathways or tools focused on common barriers affecting a seamless transitions from hospital to Home Care.	Project		Completed	08/01/2015	11/01/2015	08/01/2015	11/01/2015	12/31/2015	DY1 Q3
Task Step 3… Present best practice to the Clinical Integration & Quality Committee for approval.	Project		Completed	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4… Publish and distribute best practice and expectations of the partners to include the use of Cureator Secure Text Messaging.	Project		Not Started	01/01/2016	02/29/2016	01/01/2016	02/29/2016	03/31/2016	DY1 Q4
Task Step 5… Utilize the PPS best practice in developing a rapid response team.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 6…Ensure the scope of committed home care services and	Project		Completed	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patient acceptance of services prior to discharge.									
Task Step 7…Populate quarterly meetings with the hospital case management department and home care providers to review root-cause-analysis for re-admissions and revise best practice guidelines.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 8… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 9.. Quarterly reports will be provided to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.	Project		Not Started	01/01/2016	03/31/2019	01/01/2016	03/31/2019	03/31/2019	DY4 Q4
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	Provider	Home Care Facilities	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Evidence-based guidelines for chronic-condition management implemented.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Survey partners on existing staff training programs focused on patient risk for readmissions, evidence based medicine & chronic care management and hospice screening tools.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Outline a best practice education process designed for staff and providers utilizing industry standards such as National Home Care & Hospice (example).	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Review training model with the clinical sub-committee,	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
receive feedback & develop a training curriculum.									
Task Step 4…Utilize PMO clinical staff to communicate the training modules to all partners to define expectations of frequency & timing of roll-out.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5…Create a communication channel directly to the PMO clinical staff to provide ongoing feedback on processes.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6... Load training expectations for staff into Performance Logic	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Provider	Safety Net Hospital	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Survey partners to identify current workflows & best practices.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Establish options for care pathways or risk stratification tools focused to monitoring chronically ill patients with the goal of early identification to avoid hospital transfers; Present options to the clinical sub-committee for review & revisions.	Project		In Progress	10/01/2015	01/01/2016	10/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 3…Present recommendation of a PPS wide best practice standard to the Clinical Integration Committee for review, revision, and approval.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…Publish and communicate the approved PPS wide best practice standard to all partners with an expectation of timing for	Project		Not Started	04/01/2016	06/01/2016	04/01/2016	06/01/2016	06/30/2016	DY2 Q1

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
implementation as well as staff training & ongoing training. This includes the roll-out of Allscripts Care Director as the primary tool utilized by partners.									
Task Step 5…Gain access to Allscripts Care Director, PPS Population health management tool, for those partners who do not have current access; provide training as needed.	Project		In Progress	12/01/2015	06/01/2016	12/01/2015	06/01/2016	06/30/2016	DY2 Q1
Task Step 6…Establish a performance reporting process to track implementation, progress, and impact of changes by location utilizing Performance Logic (PMO tool) for monthly partner updates.	Project		Not Started	04/01/2016	06/01/2016	04/01/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 7…Report progress to the clinical sub-committee quarterly to review findings & plan any needed changes.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	Provider	Home Care Facilities	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Identify training needs by partner based on staffing levels, historic use of INTERACT, or unmet training needs (all sites).	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Utilize home care provider's SME to create basic training expectations identified by categories of staff.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…Use the clinical sub-committee to review/revise training plan.	Project		In Progress	12/01/2015	01/31/2016	12/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Step 4…Present training plan to the Workforce Committee for input & revisions.	Project		In Progress	12/01/2015	01/31/2016	12/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Step 5…Communicate training expectations to all partners committed to the INTERACT project.	Project		Not Started	02/01/2016	04/01/2016	02/01/2016	04/01/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 6…Input expectations into Performance Logic for monthly partner progress updates.	Project		Not Started	02/01/2016	06/01/2016	02/01/2016	06/01/2016	06/30/2016	DY2 Q1
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Identify industry or partner best practices for Advance Care Planning tools and present for discussion & planning by the clinical sub-committee. (to include EMOLST)	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Engage the Palliative Care clinical sub-committee chair to review & revise proposed best practices for Advance Care Planning Tools.	Project		Completed	07/01/2015	11/01/2015	07/01/2015	11/01/2015	12/31/2015	DY1 Q3
Task Step 3…Ensure engagement of physicians by presenting tools at designated partner physician meetings or leadership. Allow for input.	Project		In Progress	11/01/2015	01/01/2016	11/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 4…Present proposal of Advance Care Planning tools to be used PPS-wide to the Clinical Integration Committee for approval.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5…Publish & communicate the plan approved to all partners with expectations of timing for training roll-out.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6…Create a reporting process to the PMO clinical staff for implementation of the tools as well as feedback on utilization for ongoing updates to ensure process improvements.	Project		Not Started	04/01/2016	06/01/2016	04/01/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 7... Load training expectations into Performance Logic	Project		Not Started	04/01/2016	06/01/2016	04/01/2016	06/01/2016	06/30/2016	DY2 Q1
Milestone #6 Create coaching program to facilitate and support implementation.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	Provider	Home Care Facilities	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Create a coaching program outline and present to the clinical sub-committee for review & revisions.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2…Allow existing facilities utilizing INTERACT to review coaching program proposals for review & revisions.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…Publish and communicate the coaching program with a partner schedule for training that is flexible to partner/staff/provider needs.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…Input training schedule into Performance Logic (PMO Tool) to establish expectations of timing & deliverables.	Project		Not Started	01/01/2016	05/01/2016	01/01/2016	05/01/2016	06/30/2016	DY2 Q1
Task Step 5…PMO Rapid Response Team to utilize outcome data & Performance Logic updates to identify trends & report to the Clinical Integration & Quality Committee for next steps.	Project		Not Started	02/01/2016	03/31/2017	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patients and families educated and involved in planning of care using INTERACT-like principles.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Identify existing patient/family/caretaker educational programs housed at facilities or performed by CBO's.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Use existing SME's or best practices to inform a PPS foundation of education for patients/family/caretakers; Present to clinical sub-committee for review & revisions.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Invite CBO's with this expertise to review program and provide input and recommendations for use of the CBO.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Publish & communicate educational program to the	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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committed partners involved.									
Task Step 5…Input expectations into Performance Logic for monthly partner progress updates.	Project		Not Started	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1... Complete analysis to determine gap between current state and need to integration if home health and integration of behavioral health, pharmacy, and other relevant services.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2…Utilize existing best practices of partner organizations to identify clients requiring physical, behavioral and pharmacological interventions based on early identification to avoid hospital transfers; Present options to the clinical sub-committee for review & revisions.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Present recommendation of a PPS wide best practice standard to the Clinical Integration Committee for review, revision, and approval.	Project		Not Started	01/01/2016	02/29/2016	01/01/2016	02/29/2016	03/31/2016	DY1 Q4
Task Step 4…Empower the home care coordinator to ensure communication by the health care providers is coordinated.	Project		Not Started	03/01/2016	07/01/2016	03/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 5…Train home care coordinators on care coordination methodology.	Project		Not Started	03/01/2016	07/31/2016	03/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task Step 6…Publish and communicate the approved PPS wide best practice standard to all partners with an expectation of timing for implementation as well as staff training & ongoing training.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 7…Allscripts Care Director will be the primary tool utilized by partners; identify partners without access & assign access;	Project		Not Started	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1

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train staff as needed.									
Task Step 8…Ensure participating partners are utilizing the RHIO in order to access patient information.	Project		In Progress	10/01/2015	01/01/2016	10/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 9…Provide patient/caregiver training on engagement in care planning.	Project		In Progress	10/01/2015	04/01/2016	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Step 10… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.	Project		Not Started	03/01/2016	05/31/2016	03/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task Step 11.. Quarterly reports will be provided to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.	Project		Not Started	03/01/2016	05/31/2016	03/01/2016	05/31/2016	06/30/2016	DY2 Q1
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Survey partners to identify current use & capacity of telehealth/telemedicine.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Identify any immediate needs of telehealth/telemedicine.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Utilize existing capabilities to connect organizations with immediate needs & those with capacity.	Project		Not Started	01/01/2016	07/01/2016	01/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 4…Provide updates to the clinical sub-committee as to telehealth/telemedicine expansions or collaborations.	Project		Not Started	01/01/2016	07/01/2016	01/01/2016	07/01/2016	09/30/2016	DY2 Q2
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Establish a PPS wide best practice for medication reconciliation for all committed partners to utilize; maximizing IT platforms & processes currently in place. The NYHQ HANYs recognized best practice will be utilized.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2…Communicate the PPS best practice utilizing the clinical sub-committee for review & revisions.	Project		Not Started	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1
Task Step 3…Partner with partner IT teams to maximize capabilities of EHR & RHIO systems or to create access to platforms to ensure proper access to allow reviews for medication reconciliation or previous services such as lab or diagnostic testing.	Project		In Progress	10/01/2015	04/01/2016	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Service and quality outcome measures are reported to all stakeholders.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…As a clinical sub-committee, identify the top clinical	Project		In Progress	07/01/2015	10/31/2015	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
indicators that best represent the patient population, program, or process.									
Task Step 2…Establish baselines, risk adjusted as needed, of clinical indicators identified for all committed partners and compare to national or local industry benchmarks.	Project		In Progress	09/01/2015	11/01/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3…Identify risks associated with indicators as they relate to the requirements of the project to ensure adequate influence on metrics.	Project		In Progress	09/01/2015	11/01/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4…Identify tools such as Amalgam Population Health and/or Allscripts Care Director Analytics as the source of outcomes for partners; assign access & train staff as needed.	Project		In Progress	11/01/2015	12/31/2015	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5…Communicate baseline, benchmark, and risk information to the clinical sub-committee & the Clinical Integration Committee (Quality Committee) for review & feedback.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 6…Outline outliers and interventions for improvement, monitor improvement process on a quarterly basis.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 7…Establish reporting expectations for all indicators to be compiled & reported to the clinical sub-committee and Clinical Integration Committee for review & clinical process recommendations for changes to positively affect individual indicators.	Project		In Progress	10/01/2015	12/01/2015	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8…PMO clinical staff focused to rapid cycle evaluation will become the primary driver of the data to ensure tracking & progress to change. PMO staff will work directly with partners based on the feedback from the Clinical Integration Committee to influence change.	Project		In Progress	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9... Add measurement & feedback into Performance Logic for tracking at PMO level. PMO will share results will PPS	Project		In Progress	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
partners at regular intervals.									
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Document process(s) by partner of tracking engaged patients; utilization of HER patient registries, Allscripts Care Director, Event Notification (Cureator/Healthix).	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.										
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation										

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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
- confirmation of home care services										
Task Step 1…Utilize previously completed partner survey to identify current state of discharge protocols and practice.										
Task Step 2…Identify existing best practices of partner organizations to identify options for care pathways or tools focused on common barriers affecting a seamless transitions from hospital to Home Care.										
Task Step 3… Present best practice to the Clinical Integration & Quality Committee for approval.										
Task Step 4… Publish and distribute best practice and expectations of the partners to include the use of Cureator Secure Text Messaging.										
Task Step 5… Utilize the PPS best practice in developing a rapid response team.										
Task Step 6…Ensure the scope of committed home care services and patient acceptance of services prior to discharge.										
Task Step 7…Populate quarterly meetings with the hospital case management department and home care providers to review root-cause-analysis for re-admissions and revise best practice guidelines.										
Task Step 8… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.										
Task Step 9.. Quarterly reports will be provided to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.										
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.										
Task Staff trained on care model, specific to:	0	0	0	0	0	1	2	3	4	5

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- patient risks for readmission - evidence-based preventive medicine - chronic disease management										
Task Evidence-based guidelines for chronic-condition management implemented.										
Task Step 1…Survey partners on existing staff training programs focused on patient risk for readmissions, evidence based medicine & chronic care management and hospice screening tools.										
Task Step 2…Outline a best practice education process designed for staff and providers utilizing industry standards such as National Home Care & Hospice (example).										
Task Step 3…Review training model with the clinical sub-committee, receive feedback & develop a training curriculum.										
Task Step 4…Utilize PMO clinical staff to communicate the training modules to all partners to define expectations of frequency & timing of roll-out.										
Task Step 5…Create a communication channel directly to the PMO clinical staff to provide ongoing feedback on processes.										
Task Step 6... Load training expectations for staff into Performance Logic										
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	0	0	0	0	0	1	2	3	4	5
Task Step 1…Survey partners to identify current workflows & best practices.										

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Task Step 2…Establish options for care pathways or risk stratification tools focused to monitoring chronically ill patients with the goal of early identification to avoid hospital transfers; Present options to the clinical sub-committee for review & revisions.										
Task Step 3…Present recommendation of a PPS wide best practice standard to the Clinical Integration Committee for review, revision, and approval.										
Task Step 4…Publish and communicate the approved PPS wide best practice standard to all partners with an expectation of timing for implementation as well as staff training & ongoing training. This includes the roll-out of Allscripts Care Director as the primary tool utilized by partners.										
Task Step 5…Gain access to Allscripts Care Director, PPS Population health management tool, for those partners who do not have current access; provide training as needed.										
Task Step 6…Establish a performance reporting process to track implementation, progress, and impact of changes by location utilizing Performance Logic (PMO tool) for monthly partner updates.										
Task Step 7…Report progress to the clinical sub-committee quarterly to review findings & plan any needed changes.										
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.										
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	0	0	0	0	0	1	2	3	4	5
Task Step 1…Identify training needs by partner based on staffing levels, historic use of INTERACT, or unmet training needs (all sites).										
Task Step 2…Utilize home care provider's SME to create basic training expectations identified by categories of staff.										
Task Step 3…Use the clinical sub-committee to review/revise training plan.										

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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
Task Step 4…Present training plan to the Workforce Committee for input & revisions.										
Task Step 5…Communicate training expectations to all partners committed to the INTERACT project.										
Task Step 6…Input expectations into Performance Logic for monthly partner progress updates.										
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task Step 1…Identify industry or partner best practices for Advance Care Planning tools and present for discussion & planning by the clinical sub-committee. (to include EMOLST)										
Task Step 2…Engage the Palliative Care clinical sub-committee chair to review & revise proposed best practices for Advance Care Planning Tools.										
Task Step 3…Ensure engagement of physicians by presenting tools at designated partner physician meetings or leadership. Allow for input.										
Task Step 4…Present proposal of Advance Care Planning tools to be used PPS-wide to the Clinical Integration Committee for approval.										
Task Step 5…Publish & communicate the plan approved to all partners with expectations of timing for training roll-out.										
Task Step 6…Create a reporting process to the PMO clinical staff for implementation of the tools as well as feedback on utilization for ongoing updates to ensure process improvements.										
Task Step 7... Load training expectations into Performance Logic										
Milestone #6 Create coaching program to facilitate and support										

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implementation.										
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	0	0	0	0	0	1	2	3	4	5
Task Step 1…Create a coaching program outline and present to the clinical sub-committee for review & revisions.										
Task Step 2…Allow existing facilities utilizing INTERACT to review coaching program proposals for review & revisions.										
Task Step 3…Publish and communicate the coaching program with a partner schedule for training that is flexible to partner/staff/provider needs.										
Task Step 4…Input training schedule into Performance Logic (PMO Tool) to establish expectations of timing & deliverables.										
Task Step 5…PMO Rapid Response Team to utilize outcome data & Performance Logic updates to identify trends & report to the Clinical Integration & Quality Committee for next steps.										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT-like principles.										
Task Step 1…Identify existing patient/family/caretaker educational programs housed at facilities or performed by CBO's.										
Task Step 2…Use existing SME's or best practices to inform a PPS foundation of education for patients/family/caretakers; Present to clinical sub-committee for review & revisions.										
Task Step 3…Invite CBO's with this expertise to review program and provide input and recommendations for use of the CBO.										
Task Step 4…Publish & communicate educational program to the committed partners involved.										
Task Step 5…Input expectations into Performance Logic for monthly										

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partner progress updates.										
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.										
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.										
Task Step 1... Complete analysis to determine gap between current state and need to integration if home health and integration of behavioral health, pharmacy, and other relevant services.										
Task Step 2…Utilize existing best practices of partner organizations to identify clients requiring physical, behavioral and pharmacological interventions based on early identification to avoid hospital transfers; Present options to the clinical sub-committee for review & revisions.										
Task Step 3…Present recommendation of a PPS wide best practice standard to the Clinical Integration Committee for review, revision, and approval.										
Task Step 4…Empower the home care coordinator to ensure communication by the health care providers is coordinated.										
Task Step 5…Train home care coordinators on care coordination methodology.										
Task Step 6…Publish and communicate the approved PPS wide best practice standard to all partners with an expectation of timing for implementation as well as staff training & ongoing training.										
Task Step 7…Allscripts Care Director will be the primary tool utilized by partners; identify partners without access & assign access; train staff as needed.										
Task Step 8…Ensure participating partners are utilizing the RHIO in order to access patient information.										
Task Step 9…Provide patient/caregiver training on engagement in care planning.										

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

DSRIP Implementation Plan Project

NewYork-Presbyterian/Queens (PPS ID:40)

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
Task Step 10… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.										
Task Step 11.. Quarterly reports will be provided to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.										
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.										
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.										
Task Step 1…Survey partners to identify current use & capacity of telehealth/telemedicine.										
Task Step 2…Identify any immediate needs of telehealth/telemedicine.										
Task Step 3…Utilize existing capabilities to connect organizations with immediate needs & those with capacity.										
Task Step 4…Provide updates to the clinical sub-committee as to telehealth/telemedicine expansions or collaborations.										
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.										
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.										
Task Step 1…Establish a PPS wide best practice for medication reconciliation for all committed partners to utilize; maximizing IT platforms & processes currently in place. The NYHQ HANYs recognized best practice will be utilized.										
Task Step 2…Communicate the PPS best practice utilizing the clinical sub-committee for review & revisions.										
Task										

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NewYork-Presbyterian/Queens (PPS ID:40)

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
Step 3…Partner with partner IT teams to maximize capabilities of EHR & RHIO systems or to create access to platforms to ensure proper access to allow reviews for medication reconciliation or previous services such as lab or diagnostic testing.										
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1…As a clinical sub-committee, identify the top clinical indicators that best represent the patient population, program, or process.										
Task Step 2…Establish baselines, risk adjusted as needed, of clinical indicators identified for all committed partners and compare to national or local industry benchmarks.										
Task Step 3…Identify risks associated with indicators as they relate to the requirements of the project to ensure adequate influence on metrics.										
Task Step 4…Identify tools such as Amalgam Population Health and/or Allscripts Care Director Analytics as the source of outcomes for partners; assign access & train staff as needed.										
Task Step 5…Communicate baseline, benchmark, and risk information to the clinical sub-committee & the Clinical Integration Committee (Quality Committee) for review & feedback.										
Task										

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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
Step 6…Outline outliers and interventions for improvement, monitor improvement process on a quarterly basis.										
Task Step 7…Establish reporting expectations for all indicators to be compiled & reported to the clinical sub-committee and Clinical Integration Committee for review & clinical process recommendations for changes to positively affect individual indicators.										
Task Step 8…PMO clinical staff focused to rapid cycle evaluation will become the primary driver of the data to ensure tracking & progress to change. PMO staff will work directly with partners based on the feedback from the Clinical Integration Committee to influence change.										
Task Step 9... Add measurement & feedback into Performance Logic for tracking at PMO level. PMO will share results will PPS partners at regular intervals.										
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients; utilization of HER patient registries, Allscripts Care Director, Event Notification (Cureator/Healthix).										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										

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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
Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.										
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services										
Task Step 1…Utilize previously completed partner survey to identify current state of discharge protocols and practice.										
Task Step 2…Identify existing best practices of partner organizations to identify options for care pathways or tools focused on common barriers affecting a seamless transitions from hospital to Home Care.										
Task Step 3… Present best practice to the Clinical Integration & Quality Committee for approval.										
Task Step 4… Publish and distribute best practice and expectations of the partners to include the use of Cureator Secure Text Messaging.										
Task Step 5… Utilize the PPS best practice in developing a rapid response team.										
Task Step 6…Ensure the scope of committed home care services and patient acceptance of services prior to discharge.										
Task Step 7…Populate quarterly meetings with the hospital case management department and home care providers to review root-cause-analysis for re-admissions and revise best practice guidelines.										
Task Step 8… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.										
Task Step 9.. Quarterly reports will be provided to the clinical sub-committee for reviews of the effectiveness of the standard.										

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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
Adjustments will be presented to the Clinical Integration Committee for approval.										
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.										
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	6	8	8	8	8	8	8	8	8	8
Task Evidence-based guidelines for chronic-condition management implemented.										
Task Step 1…Survey partners on existing staff training programs focused on patient risk for readmissions, evidence based medicine & chronic care management and hospice screening tools.										
Task Step 2…Outline a best practice education process designed for staff and providers utilizing industry standards such as National Home Care & Hospice (example).										
Task Step 3…Review training model with the clinical sub-committee, receive feedback & develop a training curriculum.										
Task Step 4…Utilize PMO clinical staff to communicate the training modules to all partners to define expectations of frequency & timing of roll-out.										
Task Step 5…Create a communication channel directly to the PMO clinical staff to provide ongoing feedback on processes.										
Task Step 6... Load training expectations for staff into Performance Logic										
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										

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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 PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	6	8	8	8	8	8	8	8	8	8
Task Step 1…Survey partners to identify current workflows & best practices.										
Task Step 2…Establish options for care pathways or risk stratification tools focused to monitoring chronically ill patients with the goal of early identification to avoid hospital transfers; Present options to the clinical sub-committee for review & revisions.										
Task Step 3…Present recommendation of a PPS wide best practice standard to the Clinical Integration Committee for review, revision, and approval.										
Task Step 4…Publish and communicate the approved PPS wide best practice standard to all partners with an expectation of timing for implementation as well as staff training & ongoing training. This includes the roll-out of Allscripts Care Director as the primary tool utilized by partners.										
Task Step 5…Gain access to Allscripts Care Director, PPS Population health management tool, for those partners who do not have current access; provide training as needed.										
Task Step 6…Establish a performance reporting process to track implementation, progress, and impact of changes by location utilizing Performance Logic (PMO tool) for monthly partner updates.										
Task Step 7…Report progress to the clinical sub-committee quarterly to review findings & plan any needed changes.										
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.										
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	6	8	8	8	8	8	8	8	8	8
Task Step 1…Identify training needs by partner based on staffing										

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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
levels, historic use of INTERACT, or unmet training needs (all sites).										
Task Step 2…Utilize home care provider's SME to create basic training expectations identified by categories of staff.										
Task Step 3…Use the clinical sub-committee to review/revise training plan.										
Task Step 4…Present training plan to the Workforce Committee for input & revisions.										
Task Step 5…Communicate training expectations to all partners committed to the INTERACT project.										
Task Step 6…Input expectations into Performance Logic for monthly partner progress updates.										
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task Step 1…Identify industry or partner best practices for Advance Care Planning tools and present for discussion & planning by the clinical sub-committee. (to include EMOLST)										
Task Step 2…Engage the Palliative Care clinical sub-committee chair to review & revise proposed best practices for Advance Care Planning Tools.										
Task Step 3…Ensure engagement of physicians by presenting tools at designated partner physician meetings or leadership. Allow for input.										
Task Step 4…Present proposal of Advance Care Planning tools to be used PPS-wide to the Clinical Integration Committee for approval.										
Task Step 5…Publish & communicate the plan approved to all partners with expectations of timing for training roll-out.										

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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 Step 6…Create a reporting process to the PMO clinical staff for implementation of the tools as well as feedback on utilization for ongoing updates to ensure process improvements.										
Task Step 7... Load training expectations into Performance Logic										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	6	8	8	8	8	8	8	8	8	8
Task Step 1…Create a coaching program outline and present to the clinical sub-committee for review & revisions.										
Task Step 2…Allow existing facilities utilizing INTERACT to review coaching program proposals for review & revisions.										
Task Step 3…Publish and communicate the coaching program with a partner schedule for training that is flexible to partner/staff/provider needs.										
Task Step 4…Input training schedule into Performance Logic (PMO Tool) to establish expectations of timing & deliverables.										
Task Step 5…PMO Rapid Response Team to utilize outcome data & Performance Logic updates to identify trends & report to the Clinical Integration & Quality Committee for next steps.										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT-like principles.										
Task Step 1…Identify existing patient/family/caretaker educational programs housed at facilities or performed by CBO's.										
Task Step 2…Use existing SME's or best practices to inform a PPS foundation of education for patients/family/caretakers; Present to clinical sub-committee for review & revisions.										

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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 Step 3…Invite CBO's with this expertise to review program and provide input and recommendations for use of the CBO.										
Task Step 4…Publish & communicate educational program to the committed partners involved.										
Task Step 5…Input expectations into Performance Logic for monthly partner progress updates.										
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.										
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.										
Task Step 1... Complete analysis to determine gap between current state and need to integration if home health and integration of behavioral health, pharmacy, and other relevant services.										
Task Step 2…Utilize existing best practices of partner organizations to identify clients requiring physical, behavioral and pharmacological interventions based on early identification to avoid hospital transfers; Present options to the clinical sub-committee for review & revisions.										
Task Step 3…Present recommendation of a PPS wide best practice standard to the Clinical Integration Committee for review, revision, and approval.										
Task Step 4…Empower the home care coordinator to ensure communication by the health care providers is coordinated.										
Task Step 5…Train home care coordinators on care coordination methodology.										
Task Step 6…Publish and communicate the approved PPS wide best practice standard to all partners with an expectation of timing for implementation as well as staff training & ongoing training.										
Task Step 7…Allscripts Care Director will be the primary tool utilized by partners; identify partners without access & assign access;										

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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
train staff as needed.										
Task Step 8…Ensure participating partners are utilizing the RHIO in order to access patient information.										
Task Step 9…Provide patient/caregiver training on engagement in care planning.										
Task Step 10… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.										
Task Step 11.. Quarterly reports will be provided to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.										
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.										
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.										
Task Step 1…Survey partners to identify current use & capacity of telehealth/telemedicine.										
Task Step 2…Identify any immediate needs of telehealth/telemedicine.										
Task Step 3…Utilize existing capabilities to connect organizations with immediate needs & those with capacity.										
Task Step 4…Provide updates to the clinical sub-committee as to telehealth/telemedicine expansions or collaborations.										
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.										
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.										
Task										

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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
Step 1…Establish a PPS wide best practice for medication reconciliation for all committed partners to utilize; maximizing IT platforms & processes currently in place. The NYHQ HANYs recognized best practice will be utilized.										
Task Step 2…Communicate the PPS best practice utilizing the clinical sub-committee for review & revisions.										
Task Step 3…Partner with partner IT teams to maximize capabilities of EHR & RHIO systems or to create access to platforms to ensure proper access to allow reviews for medication reconciliation or previous services such as lab or diagnostic testing.										
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task Step 1…As a clinical sub-committee, identify the top clinical indicators that best represent the patient population, program, or process.										
Task Step 2…Establish baselines, risk adjusted as needed, of clinical indicators identified for all committed partners and compare to national or local industry benchmarks.										
Task Step 3…Identify risks associated with indicators as they relate to the requirements of the project to ensure adequate influence on metrics.										
Task										

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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
Step 4…Identify tools such as Amalgam Population Health and/or Allscripts Care Director Analytics as the source of outcomes for partners; assign access & train staff as needed.										
Task Step 5…Communicate baseline, benchmark, and risk information to the clinical sub-committee & the Clinical Integration Committee (Quality Committee) for review & feedback.										
Task Step 6…Outline outliers and interventions for improvement, monitor improvement process on a quarterly basis.										
Task Step 7…Establish reporting expectations for all indicators to be compiled & reported to the clinical sub-committee and Clinical Integration Committee for review & clinical process recommendations for changes to positively affect individual indicators.										
Task Step 8…PMO clinical staff focused to rapid cycle evaluation will become the primary driver of the data to ensure tracking & progress to change. PMO staff will work directly with partners based on the feedback from the Clinical Integration Committee to influence change.										
Task Step 9... Add measurement & feedback into Performance Logic for tracking at PMO level. PMO will share results will PPS partners at regular intervals.										
Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										

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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 Step 4…Document process(s) by partner of tracking engaged patients; utilization of HER patient registries, Allscripts Care Director, Event Notification (Cureator/Healthix).										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	
Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	
Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	
Educate all staff on care pathways and INTERACT-like principles.	
Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	
Create coaching program to facilitate and support implementation.	Tasks 1 and 2 end date changed to 3/31/16 to align with development of training plan
Educate patient and family/caretakers, to facilitate participation in planning of care.	
Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	
Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Tasks 1-4 end dates moved to 6/30/16 to align with dates for DOH releasing patient roster and performance data and PPS analyzing needs based on information
Use EHRs and other technical platforms to track all patients engaged in the project.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	

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IPQR Module 2.b.viii.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 2.b.viii.5 - IA Monitoring

Instructions :

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Project 3.a.i – Integration of primary care and behavioral health services

IPQR Module 3.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.

Risk #1: Patients engaged in this project must have self-management goals for care. The patient population for this project have a behavioral health diagnosis and therefore will present different challenges in regards to self-management.

Mitigation #1: Our PPS providers will work with patients to create individualized support plans that are tailored to the specific needs of the patient that will include electronic applications managed by the IT platform as well as peer involvement for care coordination.

Risk #2: The cultural stigma of patients toward behavioral health and mental health issues related to the lack of cultural awareness, the overshadowing of preventative services, and the inability to access providers.

Mitigation #2: Patient, family and community education programs that link with the Cultural Competency / Health Literacy implementation plans will help to keep patients engaged after identification. Using a patient focused approach that is aware of the cultural sensitivity of this community will augment the skill needed to interact with this patient population in a culturally-sensitive manner.

Risk #3: IT infrastructure and interoperability requirement. Due to current regulations, non-behavioral health providers will not have access to all of the EHR records on behavioral health visits. This will potentially hinder the team approach to co-location for these patients.

Mitigation #3: The PPS will mitigate this risk by working with the IT committee and the compliance team to identify consents specific to behavioral health records and implement strict workflows with auditing processes for clinical staff to access records needed.

Risk #4: The ability to create effective operational workflows that focus to care coordination and patient : provider communication in order to ensure continuous follow-up of patients.

Mitigation #4: The Clinical integration Committee and Primary Care/Behavioral Health sub-committee will focus to best practice operational workflows with the help of a PPS employed behavioral health specialists that will partner with all providers to ensure implementation of best practice standards.

Mitigation #5: The PPS will align with the resources of workforce plan to collaborate with community leaders to develop, strengthen and empower community health team workers to integrate culturally sensitive patients into the engaged population. Specific focus will begin with those patients that require complex core coordination for hypertension and one or more comorbidities. If needed, a project plan to actively recruit community health workers to fill gaps in workforce will be coordinated at the PPS level.

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Risk #6: The co-location of behavioral health services will reduce reimbursement for one partner due to the regulations of cohabitation & billing practices of bundled payments. Managed care rate differentials and lack of reimbursement could become a dis-incentive to provide both PC and BH care on the same date of service. Mitigation #6: The PMO and legal team will work with all partners involved in co-location to identify the regulations associated with this project, identify billing practices that comply with state regulations, create contractual relationships as needed to ensure compliance, ensure the project based budgeting process includes funding needs, and the VBP process includes this risk as a point of negotiation.

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IPQR Module 3.a.i.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	12,759

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
1,100	7,722	298.84%	-5,138	60.52%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cc599179	Documentation/Certification	40_PMDL3715_1_3_20160202155311_NYPQ_PCBH_3.a.i.xlsx	PCBH 3.a.i patient engagement	02/02/2016 03:53 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

NewYork-Presbyterian/Queens (PPS ID:40)

IPQR Module 3.a.i.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Identify primary care sites with capacity or need of behavioral health services utilizing the community needs assessment or input from PPS partners, CBO's, or patients. PCP sites will utilize HANYS to reach NCQA 2014 PCMH recognition as part of the 2.a.ii project.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Communicate the designated sites utilizing the clinical sub-committee for input.		Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Align the primary care sites with the PCMH (2aii) project to align Level 3 certification expectations.		Project		Completed	10/01/2015	01/01/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Review licensure threshold expectations for all sites to identify needed processes of approval; seek approvals as needed.		Project		In Progress	08/01/2015	02/28/2016	08/01/2015	02/28/2016	03/31/2016	DY1 Q4
Task Step 5…Work with the legal team to identify the billing		Project		In Progress	08/01/2015	02/28/2016	08/01/2015	02/28/2016	03/31/2016	DY1 Q4

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practices for co-located services to ensure compliance.										
Task Step 6…Upon feedback of capital funding, plan for any construction needs by site. PPS partner to manage their own capital & construction needs.		Project		In Progress	10/01/2015	04/01/2016	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Step 7…Outline a timeline/roll-out schedule of all participating clinics that shows anticipated clinic start dates & availability.		Project		Not Started	01/01/2016	06/01/2016	01/01/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 8…Communicate timeline to PPS network informing them of the new access point for behavioral health services.		Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9…Train staff to ensure full understanding of operational processes, sensitivity, cultural competency, and behavioral health related medical record policies.		Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 10…Recruit behavioral health care providers based on need of site (Physician/Social Worker/etc.)		Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 11…Create scheduling templates for new providers & patients.		Project		In Progress	09/01/2015	07/01/2016	09/01/2015	07/01/2016	09/30/2016	DY2 Q2
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Identify existing best practice (evidence-based)		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2

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standards utilizing partner expertise & experience.										
Task Step 2…Present best practice proposals to the clinical sub-committee for review & recommendation to the Clinical Integration & Quality Committee.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Seek approval of the Clinical Integration & Quality Committee.		Project		Completed	01/01/2016	03/31/2016	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Configure care coordination software (Allscripts Care Director) for the use of the approved best practice standards.		Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task Step 5…PMO IT staff to ensure all partners have access to Allscripts Care Director & adequate training for use of tool.		Project		Not Started	05/01/2016	12/31/2016	05/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6…Publish & communicate the approved PPS best practice standard including medication management to the PPS network.		Project		Not Started	04/01/2016	10/01/2016	04/01/2016	10/01/2016	12/31/2016	DY2 Q3
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 1	Project	N/A	In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task Screenings are documented in Electronic Health Record.		Project		In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task 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).		Project		In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Electronic Health Record.										
Task Step 1…PMO staff to identify existing best practices at PPS partner locations including preventative care screenings (PHQ-2 or 9 & SBIRT) & processes for "warm transfer."		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Clinical Committee Chair to present the findings from Step 1 to the clinical sub committee for review & recommendations of standardization of best practices.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…PMO IT staff to present the best practice standards recommended to the EHR vendors for feedback & to ensure set-up for implementation.		Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…PMO IT staff to identify paper based practices & process for tracking preventative screenings.		Project		In Progress	07/01/2015	01/01/2016	07/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 5…PMO IT staff and Committee Chair to present paper based process to the clinical sub committee for review.		Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 6…Committee Chair to present the best practice recommendations (paper & EMR) to the Clinical Integration & Quality Committee for approval.		Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Communicate & discuss the definition of 'engaged		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.		Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Document process(s) by partner of tracking engaged patients.		Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 5…Utilize EHRs or other platforms (RHIO's, EHR patient registries) to track engaged patients & report to the PMO monthly regarding volume/performance.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health sites.	Model 2	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Identify behavioral health sites with capacity or need of primary care utilizing the community needs assessment or input from PPS partners, CBO's, or patients. PCP sites will utilize HANYs consultant to reach NCQA 2014 PCMH recognition as part of project 2.a.ii.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Communicate the designated sites utilizing the		Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3

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clinical sub-committee for input.										
Task Step 3…Review licensure threshold expectations for all sites to identify needed processes of approval; seek approvals as needed.		Project		In Progress	10/01/2015	01/01/2016	10/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 4…Work with the legal team to identify the billing practices for co-located services to ensure compliance.		Project		In Progress	08/01/2015	02/28/2016	08/01/2015	02/28/2016	03/31/2016	DY1 Q4
Task Step 5…Upon feedback of capital funding, plan for any construction needs by site. PPS partner to manage their own capital & construction needs.		Project		In Progress	10/01/2015	04/01/2016	10/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Step 6…Outline a timeline/roll-out schedule of all participating clinics that shows anticipated clinic start dates & availability.		Project		Not Started	01/01/2016	06/01/2016	01/01/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 7…Communicate timeline to PPS network informing them of the new access point for behavioral health services.		Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8…Train staff to ensure full understanding of operational processes.		Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 9…Recruit or re-allocate primary care providers to sites based on need (MD vs. NP vs. PA)		Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 10…Create scheduling templates for new providers & patients.		Project		In Progress	09/01/2015	07/01/2016	09/01/2015	07/01/2016	09/30/2016	DY2 Q2
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.		Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 1…Identify existing best practice (evidence-based) standards utilizing partner expertise & experience.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Present best practice proposals to the clinical sub-committee for review & recommendation to the Clinical Integration & Quality Committee.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Seek approval of the Clinical Integration & Quality Committee.		Project		Completed	01/01/2016	03/31/2016	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Configure care coordination software (Allscripts Care Director) for the use of the approved best practice standards.		Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task Step 5…PMO IT staff to ensure all partners have access to Allscripts Care Director & adequate training for use of tool.		Project		Not Started	05/01/2016	12/31/2016	05/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6…Publish & communicate the approved PPS best practice standard including medication management to the PPS network.		Project		Not Started	04/01/2016	10/01/2016	04/01/2016	10/01/2016	12/31/2016	DY2 Q3
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.	Model 2	Project	N/A	In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task Screenings are documented in Electronic Health Record.		Project		In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task		Project		In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2

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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).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	08/01/2016	07/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task Step 1…PMO staff to identify existing best practices at PPS partner locations related to preventative care screenings (PHQ-2 or 9 & SBIRT) & processes for "warm transfer."		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Clinical Committee Chair to present the findings from Step 1 to the clinical sub committee for review & recommendations of standardization of best practices.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…PMO IT staff to present the best practice standards recommended to the EHR vendors for feedback & to ensure set-up for implementation.		Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…PMO IT staff to identify paper based practices & process for tracking preventative screenings.		Project		In Progress	07/01/2015	01/01/2016	07/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 5…PMO IT staff and Committee Chair to present paper based process to the clinical sub committee for review.		Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 6…Committee Chair to present the best practice recommendations (paper & EMR) to the Clinical Integration & Quality Committee for approval.		Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 2	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.		Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Document process(s) by partner of tracking engaged patients.		Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 5…Utilize EHRs or other platforms (RHIO's, EHR patient registries) to track engaged patients & report to the PMO monthly regarding volume/performance.		Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 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.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 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).		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 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.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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 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.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	0	1	1	2	3	4
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	0	0	2	4	7	11	15
Task Step 1…Identify primary care sites with capacity or need of behavioral health services utilizing the community needs assessment or input from PPS partners, CBO's, or patients. PCP sites will utilize HANYS to reach NCQA 2014 PCMH recognition as part of the 2.a.ii project.										
Task Step 2…Communicate the designated sites utilizing the clinical sub-committee for input.										
Task Step 3…Align the primary care sites with the PCMH (2aii) project to align Level 3 certification expectations.										
Task Step 4…Review licensure threshold expectations for all sites to identify needed processes of approval; seek approvals as needed.										

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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
Task Step 5…Work with the legal team to identify the billing practices for co-located services to ensure compliance.										
Task Step 6…Upon feedback of capital funding, plan for any construction needs by site. PPS partner to manage their own capital & construction needs.										
Task Step 7…Outline a timeline/roll-out schedule of all participating clinics that shows anticipated clinic start dates & availability.										
Task Step 8…Communicate timeline to PPS network informing them of the new access point for behavioral health services.										
Task Step 9…Train staff to ensure full understanding of operational processes, sensitivity, cultural competency, and behavioral health related medical record policies.										
Task Step 10…Recruit behavioral health care providers based on need of site (Physician/Social Worker/etc.)										
Task Step 11…Create scheduling templates for new providers & patients.										
Milestone #2 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 medication management and care engagement processes.										
Task Step 1…Identify existing best practice (evidence-based) standards utilizing partner expertise & experience.										
Task Step 2…Present best practice proposals to the clinical sub-committee for review & recommendation to the Clinical Integration & Quality Committee.										
Task Step 3…Seek approval of the Clinical Integration & Quality										

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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
Committee.										
Task Step 4…Configure care coordination software (Allscripts Care Director) for the use of the approved best practice standards.										
Task Step 5…PMO IT staff to ensure all partners have access to Allscripts Care Director & adequate training for use of tool.										
Task Step 6…Publish & communicate the approved PPS best practice standard including medication management to the PPS network.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task 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).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	1	1	2	3	4
Task Step 1…PMO staff to identify existing best practices at PPS partner locations including preventative care screenings (PHQ-2 or 9 & SBIRT) & processes for "warm transfer."										
Task Step 2…Clinical Committee Chair to present the findings from Step 1 to the clinical sub committee for review & recommendations of standardization of best practices.										
Task Step 3…PMO IT staff to present the best practice standards recommended to the EHR vendors for feedback & to ensure set-up for implementation.										
Task Step 4…PMO IT staff to identify paper based practices & process for tracking preventative screenings.										

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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
Task Step 5…PMO IT staff and Committee Chair to present paper based process to the clinical sub committee for review.										
Task Step 6…Committee Chair to present the best practice recommendations (paper & EMR) to the Clinical Integration & Quality Committee for approval.										
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 Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms (RHIO's, EHR patient registries) to track engaged patients & report to the PMO monthly regarding volume/performance.										
Milestone #5 Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	0	0	0	0	0	1	1	2	3	4
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	1	1	2	3	4
Task	0	0	0	0	0	2	4	7	11	15

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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
Primary care services are co-located within behavioral Health practices and are available.										
Task Step 1…Identify behavioral health sites with capacity or need of primary care utilizing the community needs assessment or input from PPS partners, CBO's, or patients. PCP sites will utilize HANYs consultant to reach NCQA 2014 PCMH recognition as part of project 2.a.ii.										
Task Step 2…Communicate the designated sites utilizing the clinical sub-committee for input.										
Task Step 3…Review licensure threshold expectations for all sites to identify needed processes of approval; seek approvals as needed.										
Task Step 4…Work with the legal team to identify the billing practices for co-located services to ensure compliance.										
Task Step 5…Upon feedback of capital funding, plan for any construction needs by site. PPS partner to manage their own capital & construction needs.										
Task Step 6…Outline a timeline/roll-out schedule of all participating clinics that shows anticipated clinic start dates & availability.										
Task Step 7…Communicate timeline to PPS network informing them of the new access point for behavioral health services.										
Task Step 8…Train staff to ensure full understanding of operational processes.										
Task Step 9…Recruit or re-allocate primary care providers to sites based on need (MD vs. NP vs. PA)										
Task Step 10…Create scheduling templates for new providers & 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										

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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
collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.										
Task Step 1…Identify existing best practice (evidence-based) standards utilizing partner expertise & experience.										
Task Step 2…Present best practice proposals to the clinical sub-committee for review & recommendation to the Clinical Integration & Quality Committee.										
Task Step 3…Seek approval of the Clinical Integration & Quality Committee.										
Task Step 4…Configure care coordination software (Allscripts Care Director) for the use of the approved best practice standards.										
Task Step 5…PMO IT staff to ensure all partners have access to Allscripts Care Director & adequate training for use of tool.										
Task Step 6…Publish & communicate the approved PPS best practice standard including medication management to the PPS network.										
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 and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task 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).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	1	1	2	3	4

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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
Task Step 1…PMO staff to identify existing best practices at PPS partner locations related to preventative care screenings (PHQ-2 or 9 & SBIRT) & processes for "warm transfer."										
Task Step 2…Clinical Committee Chair to present the findings from Step 1 to the clinical sub committee for review & recommendations of standardization of best practices.										
Task Step 3…PMO IT staff to present the best practice standards recommended to the EHR vendors for feedback & to ensure set-up for implementation.										
Task Step 4…PMO IT staff to identify paper based practices & process for tracking preventative screenings.										
Task Step 5…PMO IT staff and Committee Chair to present paper based process to the clinical sub committee for review.										
Task Step 6…Committee Chair to present the best practice recommendations (paper & EMR) to the Clinical Integration & Quality Committee for approval.										
Milestone #8 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 Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										

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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
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms (RHIO's, EHR patient registries) to track engaged patients & report to the PMO monthly regarding volume/performance.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	1	1	2	3	4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task 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.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task 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.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										

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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
Task 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).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task 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.										
Milestone #15 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.										

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
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	6	7	9	11	13	15	15	15	15	15
Task Behavioral health services are co-located within PCMH/APC practices and are available.	20	25	31	38	45	53	53	53	53	53
Task Step 1…Identify primary care sites with capacity or need of behavioral health services utilizing the community needs assessment or input from PPS partners, CBO's, or patients. PCP sites will utilize HANYS to reach NCQA 2014 PCMH recognition as part of the 2.a.ii project.										
Task Step 2…Communicate the designated sites utilizing the clinical sub-committee for input.										

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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 Step 3…Align the primary care sites with the PCMH (2aii) project to align Level 3 certification expectations.										
Task Step 4…Review licensure threshold expectations for all sites to identify needed processes of approval; seek approvals as needed.										
Task Step 5…Work with the legal team to identify the billing practices for co-located services to ensure compliance.										
Task Step 6…Upon feedback of capital funding, plan for any construction needs by site. PPS partner to manage their own capital & construction needs.										
Task Step 7…Outline a timeline/roll-out schedule of all participating clinics that shows anticipated clinic start dates & availability.										
Task Step 8…Communicate timeline to PPS network informing them of the new access point for behavioral health services.										
Task Step 9…Train staff to ensure full understanding of operational processes, sensitivity, cultural competency, and behavioral health related medical record policies.										
Task Step 10…Recruit behavioral health care providers based on need of site (Physician/Social Worker/etc.)										
Task Step 11…Create scheduling templates for new providers & patients.										
Milestone #2 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 medication management and care engagement processes.										
Task Step 1…Identify existing best practice (evidence-based)										

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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
standards utilizing partner expertise & experience.										
Task Step 2…Present best practice proposals to the clinical sub-committee for review & recommendation to the Clinical Integration & Quality Committee.										
Task Step 3…Seek approval of the Clinical Integration & Quality Committee.										
Task Step 4…Configure care coordination software (Allscripts Care Director) for the use of the approved best practice standards.										
Task Step 5…PMO IT staff to ensure all partners have access to Allscripts Care Director & adequate training for use of tool.										
Task Step 6…Publish & communicate the approved PPS best practice standard including medication management to the PPS network.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task 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).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	6	7	9	11	13	15	15	15	15	15
Task Step 1…PMO staff to identify existing best practices at PPS partner locations including preventative care screenings (PHQ-2 or 9 & SBIRT) & processes for "warm transfer."										
Task Step 2…Clinical Committee Chair to present the findings from Step 1 to the clinical sub committee for review & recommendations of standardization of best practices.										

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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 Step 3…PMO IT staff to present the best practice standards recommended to the EHR vendors for feedback & to ensure set-up for implementation.										
Task Step 4…PMO IT staff to identify paper based practices & process for tracking preventative screenings.										
Task Step 5…PMO IT staff and Committee Chair to present paper based process to the clinical sub committee for review.										
Task Step 6…Committee Chair to present the best practice recommendations (paper & EMR) to the Clinical Integration & Quality Committee for approval.										
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 Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms (RHIO's, EHR patient registries) to track engaged patients & report to the PMO monthly regarding volume/performance.										
Milestone #5 Co-locate primary care services at behavioral health sites.										

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Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	6	7	9	11	13	15	15	15	15	15
Task Primary care services are co-located within behavioral Health practices and are available.	6	7	9	11	13	15	15	15	15	15
Task Primary care services are co-located within behavioral Health practices and are available.	20	25	31	38	45	53	53	53	53	53
Task Step 1…Identify behavioral health sites with capacity or need of primary care utilizing the community needs assessment or input from PPS partners, CBO's, or patients. PCP sites will utilize HANYs consultant to reach NCQA 2014 PCMH recognition as part of project 2.a.ii.										
Task Step 2…Communicate the designated sites utilizing the clinical sub-committee for input.										
Task Step 3…Review licensure threshold expectations for all sites to identify needed processes of approval; seek approvals as needed.										
Task Step 4…Work with the legal team to identify the billing practices for co-located services to ensure compliance.										
Task Step 5…Upon feedback of capital funding, plan for any construction needs by site. PPS partner to manage their own capital & construction needs.										
Task Step 6…Outline a timeline/roll-out schedule of all participating clinics that shows anticipated clinic start dates & availability.										
Task Step 7…Communicate timeline to PPS network informing them of the new access point for behavioral health services.										
Task Step 8…Train staff to ensure full understanding of operational processes.										
Task Step 9…Recruit or re-allocate primary care providers to sites based on need (MD vs. NP vs. PA)										
Task Step 10…Create scheduling templates for new providers &										

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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
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 Step 1…Identify existing best practice (evidence-based) standards utilizing partner expertise & experience.										
Task Step 2…Present best practice proposals to the clinical sub-committee for review & recommendation to the Clinical Integration & Quality Committee.										
Task Step 3…Seek approval of the Clinical Integration & Quality Committee.										
Task Step 4…Configure care coordination software (Allscripts Care Director) for the use of the approved best practice standards.										
Task Step 5…PMO IT staff to ensure all partners have access to Allscripts Care Director & adequate training for use of tool.										
Task Step 6…Publish & communicate the approved PPS best practice standard including medication management to the PPS network.										
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 and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established										

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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
project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	6	7	9	11	13	15	15	15	15	15
Task Step 1…PMO staff to identify existing best practices at PPS partner locations related to preventative care screenings (PHQ-2 or 9 & SBIRT) & processes for "warm transfer."										
Task Step 2…Clinical Committee Chair to present the findings from Step 1 to the clinical sub committee for review & recommendations of standardization of best practices.										
Task Step 3…PMO IT staff to present the best practice standards recommended to the EHR vendors for feedback & to ensure set-up for implementation.										
Task Step 4…PMO IT staff to identify paper based practices & process for tracking preventative screenings.										
Task Step 5…PMO IT staff and Committee Chair to present paper based process to the clinical sub committee for review.										
Task Step 6…Committee Chair to present the best practice recommendations (paper & EMR) to the Clinical Integration & Quality Committee for approval.										
Milestone #8 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 Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										

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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 Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms (RHIO's, EHR patient registries) to track engaged patients & report to the PMO monthly regarding volume/performance.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	6	7	9	11	13	15	15	15	15	15
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task 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.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task 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.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT										

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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
Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task 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).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task 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.										
Milestone #15 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.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Co-locate primary care services at behavioral health sites.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
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.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Implement IMPACT Model at Primary Care Sites.	
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	
Designate a Psychiatrist meeting requirements of the IMPACT Model.	
Measure outcomes as required in the IMPACT Model.	
Provide "stepped care" as required by the IMPACT Model.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	

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IPQR Module 3.a.i.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 3.a.i.5 - IA Monitoring

Instructions :

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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.

Risk #1: Coordinating with the implementation speed of the Patient Centered Medical Home recognition (Project 2.a.ii) and meeting PCMH level 3 targets. This risk may directly associate with the level of speed and scale attributed to this project.

Mitigation #1: Inherent to a successful mitigation strategy for adaptation of evidence-based care pathways and standardization for cardiovascular disease risk reduction is to coordinate timing of standardized strategies with implementation of the PCMH initiatives. The PPS will need to coordinate activities within the different project work plans to ensure collaboration with the PCMH initiatives, without slighting either of these two projects or undermining the other projects, such as behavioral health integration. Current state assessment of cardiovascular disease prevention initiatives that are already a component of the existing PCMH framework will be used as a springboard to enhance collaboration with health care providers to heighten cardiovascular prevention awareness as a means to improve patient outcomes.

Risk #3: The potential for low compliance of both patients and practitioners.

Mitigation #3: This risk will be mitigated by utilizing the practitioner engagement committee to ensure that providers are knowledgeable about DSRIP and utilizing best practices across the PPS. Patients will be engaged through education, possible IT solutions including portal messaging etc. to ensure that they are compliant with their self-management goals.

Risk #4: Ensuring primary care practitioner engagement of 80% of the PPS PCP network for all project requirements.

Mitigation #4: The PPS has individually reviewed and discussed expectations with all primary care providers regarding all projects and will ensure continued development of the PPS network in order to increase the provider network where needed as well as provider education as needed.

Risk #5: The ability to build a culturally competent system by partnering with the PPS CBO's in order to maximize community awareness and engagement related to prevention and cultural changes needed to impact the health of this population.

Mitigation #5: The PPS will engage all CBO's in the sub-committees and clinical planning in order to maximize existing practices or build new best practices focused to cardiovascular health & prevention.

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

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	3,630

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
561	3,226	177.74%	-1,411	88.87%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cc599179	Documentation/Certification	40_PMDL4215_1_3_20160202155530_NYPQ_Cardiovascular_3.b.i.xlsx	Cardiovascular 3.b.i patient engagement	02/02/2016 03:56 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 3.b.i.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Utilize the clinical sub-committee to outline evidence-based strategies utilizing existing practices or industry standards.	Project		Completed	08/01/2015	11/01/2015	08/01/2015	11/01/2015	12/31/2015	DY1 Q3
Task Step 2…Present evidence-based strategies to the Clinical Integration Committee for review & approval.	Project		Completed	11/01/2015	01/01/2016	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Create a roll-out schedule with defined risks including all partners involved.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Establish reporting expectations of partners for outlined indicators that relate to the evidence-based strategies to monitor quarterly to show outcomes. Utilize the PMO clinical team as a resource to track/trend/interpret the reports in order to suggest changes.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5…Present reports to the clinical sub-committee for input into program based on outcomes.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Utilize survey of all partners outlined in the IT Implementation Plan to establish current IT state to include EHR usage, and RHIO access.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 2…Identify gaps of electronic health record use or RHIO involvement from the survey and discuss needs with PPS partners.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…Create a roll-out schedule for those committed partners identified in the gap assessment to move to an EHR or RHIO use for access to electronic health records.	Project		Not Started	04/01/2016	06/01/2016	04/01/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 4…Provide funding information & options to paper based providers to help assist with financial needs of EMR implementation.	Project		Not Started	04/01/2016	07/01/2016	04/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 5…Present the roll-out schedule to the IT Committee for review & final recommendation for approval to the Clinical Integration Committee for the initiation of implementation.	Project		Not Started	07/01/2016	09/01/2016	07/01/2016	09/01/2016	09/30/2016	DY2 Q2
Task Step 6…Include the roll-out schedule in Performance Logic (PMO Tool) to outline timing & expectations for progress to be	Project		Not Started	04/01/2016	10/31/2016	04/01/2016	10/31/2016	12/31/2016	DY2 Q3

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tracked & input by partners. Information will be used for progress reports and PPS dashboards to ensure timely completion.									
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	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	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	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Utilize the IT survey outlined in the Organization Implementation Plan to identify partners with no EHR or EHR's that do not meet Meaning Use expectations.	Project		Not Started	03/01/2016	06/01/2016	03/01/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 2…Follow the plan outlined in the IT Implementation Plan to identify a road map & timing to close the gap for non-EHR use or MU inadequacies.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3…Provide ongoing feedback to the clinical sub-committee regarding connectivity or issues identified.	Project		Not Started	03/01/2016	07/01/2016	03/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 4…Provide feedback to the clinical sub-committee as to IT expectations & progress.	Project		Not Started	03/31/2016	03/31/2018	03/31/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 1…Communicate & discuss the definition of 'DSRIP engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
aware of expectations.									
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Document processed(s) by partner of tracking engaged patients.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Provide education to the PPS partners of the 5 A's by inviting a SME to the clinical sub-committee and ensure the inclusion of an IT representative for proper tracking.	Project		Completed	11/01/2015	01/01/2016	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2…Establish current tracking processes of all partners for the 5 A's; document & identify gaps.	Project		In Progress	09/01/2015	12/01/2015	10/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 3…Create a plan for an automated scheduling system to facilitate tobacco control protocols.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…Provide monthly/quarterly updates to the clinical sub-committee.	Project		In Progress	09/01/2015	12/31/2015	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Milestone #6 Adopt and follow standardized treatment protocols for	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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).	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize the clinical sub-committee to outline evidence-based protocols utilizing existing practices or industry standard for elevated cholesterol & hypertension.	Project		Completed	08/01/2015	11/01/2015	08/01/2015	11/01/2015	12/31/2015	DY1 Q3
Task Step 2…Provide educational opportunities for partners by SME's with knowledge of NCEP or USPSTF to ensure informed decisions of the protocols.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Present evidence-based protocols to the Clinical Integration Committee for review & approval.	Project		In Progress	11/01/2015	01/31/2016	11/01/2015	01/31/2016	03/31/2016	DY1 Q4
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize previously completed partner survey team members, strengths and best practice .	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2.. The team to agree upon a screen tool to identify high risk cardiac patient and standardized best practice guidelines establish care coordination and goals and recommendation.	Project		Completed	08/01/2015	10/31/2015	08/01/2015	10/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 3… Present best practice to the Clinical Integration & Quality Committee for approval.	Project		Completed	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4… Publish and distribute best practice and expectations of the partners.	Project		Not Started	01/01/2016	02/29/2016	01/01/2016	02/29/2016	03/31/2016	DY1 Q4
Task Step 5… Implement the PPS best practice utilizing the PMO clinical staff as an implementation resource.	Project		Not Started	02/01/2016	05/01/2016	02/01/2016	05/01/2016	06/30/2016	DY2 Q1
Task Step 6…Update IT platforms to ensuring formatting of the updated & approved best practice form.	Project		Not Started	01/01/2016	07/01/2016	01/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 7… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.	Project		In Progress	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8.. Report quarterly to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Clinical sub-committee to establish a PPS best practice for access points for engaged patients to receive BP checks.	Project		Completed	08/01/2015	10/31/2015	08/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 2…Outline workforce need for BP access points.	Project		Completed	08/01/2015	11/30/2015	08/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Step 3…Document & communicate BP access point best practice expectations to all partners.	Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4... PPS staff to communicate to high risk patients, i.e. patients with hypertension, ability to have blood pressure check	Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
without an appointment									
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Clinical sub-committee to establish expectations of process of blood pressure monitoring & equipment needs to ensure PPS consistency.	Project		Completed	08/01/2015	10/31/2015	08/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task Step 2…PPS partners to identify training needs of staff/providers related to BP measurements.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Provide educational opportunities to staff related to BP measurements.	Project		Not Started	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1
Task Step 4... Ensure office scheduling scheduling is completed that blood pressure checks can be completed without appointments as needed	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
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.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Clinical sub-committee to define parameters of	Project		Completed	08/01/2015	12/01/2015	08/01/2015	12/01/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
'hypertension' & outline the tool being utilized (AHA, etc.). Present the best practice to the Clinical Integration Committee for review & approval.									
Task Step 2…Clinical sub-committee to define the frequency of monitoring parameters of Step 1 defined 'hypertensive' patients to include monitoring expectations.	Project		Completed	08/01/2015	11/30/2015	08/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Step 3…Ensure provider schedules are flexible to allow for proper appointment scheduling of undiagnosed hypertension patients.	Project		In Progress	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…Communicate best practice expectations & hypertension parameters to all partners; PMO clinical staff to work with clinics for the implementation of best practices.	Project		Not Started	01/01/2016	07/01/2016	01/01/2016	07/01/2016	09/30/2016	DY2 Q2
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Clinical sub-committee to establish a PPS best practice for once-daily regimens or fixed dose combination pills.	Project		Completed	08/01/2015	12/01/2015	08/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 2…Present best practice to the Clinical Integration Committee for review & approval.	Project		In Progress	12/01/2015	02/01/2016	12/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 3…Publish & communicate best practice; PMO clinical team to work with partners to implement best practices.	Project		Not Started	02/01/2016	07/01/2016	02/01/2016	07/01/2016	09/30/2016	DY2 Q2
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Self-management goals are documented in the clinical record.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on person-centered	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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methods that include documentation of self-management goals.									
Task Step 1…Clinical sub-committee to define self-management goal clinical expectations & outline IT expectations for tracking.	Project		Completed	08/01/2015	12/01/2015	08/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 2…Ensure IT personnel input into process by invitations to each clinical sub-committee.	Project		Completed	08/01/2015	12/01/2015	08/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…Communicate self-management expectations to all partners & ensure capability.	Project		Not Started	01/01/2016	06/01/2016	01/01/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 4…Define educational needs of staff / providers & establish educational opportunities.	Project		Not Started	01/01/2016	07/01/2016	01/01/2016	07/01/2016	09/30/2016	DY2 Q2
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Survey Home Care agencies to identify current clinical state for community based programs to include behavioral health options.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Clinical sub-committee to create best practice standards for referrals to ensure referral & follow-up of patients.	Project		In Progress	10/01/2015	01/31/2016	10/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Step 3…Present best practice to the Clinical Integration Committee for review & approval.	Project		Not Started	02/01/2016	05/01/2016	02/01/2016	05/01/2016	06/30/2016	DY2 Q1
Task	Project		Not Started	05/01/2016	09/01/2016	05/01/2016	09/01/2016	09/30/2016	DY2 Q2

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Step 4…Communicate best practice expectations to all partners; PMO clinical staff to become a resource for implementation.									
Task Step 5…Establish relationships with providers & community based resource options.	Project		Not Started	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
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.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…PMO to request Home Care best practices currently in use to outline current clinical practice.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 2…Clinical sub-committee to review all current practices & identify PPS protocol for home blood pressure monitoring.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Present best practice to the Clinical Integration Committee for review & approval.	Project		Not Started	02/01/2016	05/01/2016	02/01/2016	05/01/2016	06/30/2016	DY2 Q1
Task Step 4…Communicate best practice expectations to all partners; PMO clinical staff to become a resource for implementation.	Project		Not Started	05/01/2016	09/01/2016	05/01/2016	09/01/2016	09/30/2016	DY2 Q2
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize EMR registry options track engaged patients &	Project		Not Started	01/01/2016	05/01/2016	01/01/2016	05/01/2016	06/30/2016	DY2 Q1

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utilization of follow-up care.									
Task Step 2…Define parameters of expectations of follow-up care utilizing the clinical sub-committee.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…Create an automated scheduling process of patients in the registry that do not meet the parameters of follow-up.	Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task Step 4…Create a reporting expectation of the EMR patient registry with metrics & parameters.	Project		Not Started	04/01/2016	10/01/2016	04/01/2016	10/01/2016	12/31/2016	DY2 Q3
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Ensure all partners have information for referrals to the NYS Smoker's Quitline through an educational presentation to the clinical sub-committee.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 2…Facilitate ongoing dialogue regarding complexities or issues identified with the referral process utilizing the clinical sub-committee.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 3…Utilize the NYS provider education program to provider & staff education specific to the NYS Quitline.	Project		Not Started	03/01/2016	03/31/2017	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has established linkages to health homes for	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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targeted patient populations.									
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…PMO clinical rapid response team will identify "hot spotting" expectations focused to cardiovascular disease & utilize PMO staff to complete necessary reports of REAL information as deemed by the PMO or need of the clinical sub-committee.	Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task Step 2…Information obtained by the PMO will be shared with the clinical sub-committee based on outcomes.	Project		Not Started	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3..Clinical sub-committee will make recommendations for programmatic changes based on input & outcomes of the existing program.	Project		Not Started	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #18 Adopt strategies from the Million Hearts Campaign.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Mental Health	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Allow informational presentation of the Million Hearts Campaign to the clinical sub-committee to ensure full involvement.	Project		In Progress	11/01/2015	01/01/2016	11/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 2…Clinical sub-committee to outline strategies appropriate to the PPS engaged patient population & create PPS wide	Project		Not Started	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1

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expectations of strategy use.									
Task Step 3…Document & communicate the Million Hearts Campaign strategies to all partners.	Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task Step 4…Create a staff education model, if needed, for MHC strategies.	Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
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.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Survey partners to identify current clinical practices and uncovered services related to the cardiology program.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Identify areas of best practice that have impacted the patient population with cost reduction or quality indicator improvements to create a PPS improvement listing.	Project		In Progress	10/01/2015	12/31/2015	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3…Engage MCD MCO organizations in each clinical sub-committee to ensure full understanding of processes & projects.	Project		Not Started	02/01/2016	05/01/2016	02/01/2016	05/01/2016	06/30/2016	DY2 Q1
Task Step 4…PMO to analyze quality & payer-data to identify negotiation potentials, strengths, and weaknesses.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5…PMO to communicate the findings in Step 4 to all partners involved for individual MCO negotiations.	Project		Not Started	07/01/2016	10/01/2016	07/01/2016	10/01/2016	12/31/2016	DY2 Q3
Task Step 6…Requirement will be loaded into Performance Logic for quarterly updates from all partners.	Project		Not Started	07/01/2016	10/01/2016	07/01/2016	10/01/2016	12/31/2016	DY2 Q3
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Define PCP's in PPS network according to the NYS published network listing & communicate to the clinical sub-committee.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2…Ensure all PCP's outlined above are invited to clinical sub-committee meetings.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 3..Complete partner agreements for partners involved in the project with details of expectations of deliverables.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Utilize PMO clinical staff to follow-up with unengaged partners to meet the 80% expectation.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5…Continue to network with providers in the community in order to maximize provider network during allotted NYS enrollment periods.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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 program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task Step 1…Utilize the clinical sub-committee to outline evidence-based strategies utilizing existing practices or industry standards.										
Task Step 2…Present evidence-based strategies to the Clinical Integration Committee for review & approval.										
Task Step 3…Create a roll-out schedule with defined risks including all partners involved.										

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Task Step 4…Establish reporting expectations of partners for outlined indicators that relate to the evidence-based strategies to monitor quarterly to show outcomes. Utilize the PMO clinical team as a resource to track/trend/interpret the reports in order to suggest changes.										
Task Step 5…Present reports to the clinical sub-committee for input into program based on outcomes.										
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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	8	16	20	25	32	39
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	1	3	7	11	15
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task PPS uses alerts and secure messaging functionality.										
Task Step 1…Utilize survey of all partners outlined in the IT Implementation Plan to establish current IT state to include EHR usage, and RHIO access.										
Task Step 2…Identify gaps of electronic health record use or RHIO involvement from the survey and discuss needs with PPS partners.										
Task Step 3…Create a roll-out schedule for those committed partners identified in the gap assessment to move to an EHR or RHIO use for access to electronic health records.										
Task Step 4…Provide funding information & options to paper based providers to help assist with financial needs of EMR implementation.										
Task										

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Step 5…Present the roll-out schedule to the IT Committee for review & final recommendation for approval to the Clinical Integration Committee for the initiation of implementation.										
Task Step 6…Include the roll-out schedule in Performance Logic (PMO Tool) to outline timing & expectations for progress to be tracked & input by partners. Information will be used for progress reports and PPS dashboards to ensure timely completion.										
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.										
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.	0	0	0	0	8	18	30	45	63	83
Task Step 1…Utilize the IT survey outlined in the Organization Implementation Plan to identify partners with no EHR or EHR's that do not meet Meaning Use expectations.										
Task Step 2…Follow the plan outlined in the IT Implementation Plan to identify a road map & timing to close the gap for non-EHR use or MU inadequacies.										
Task Step 3…Provide ongoing feedback to the clinical sub-committee regarding connectivity or issues identified.										
Task Step 4…Provide feedback to the clinical sub-committee as to IT expectations & progress.										
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 Step 1…Communicate & discuss the definition of 'DSRIP engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are										

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aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document processed(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										
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 Step 1…Provide education to the PPS partners of the 5 A's by inviting a SME to the clinical sub-committee and ensure the inclusion of an IT representative for proper tracking.										
Task Step 2…Establish current tracking processes of all partners for the 5 A's; document & identify gaps.										
Task Step 3…Create a plan for an automated scheduling system to facilitate tobacco control protocols.										
Task Step 4…Provide monthly/quarterly updates to the clinical sub-committee.										
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										

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(NCEP) or US Preventive Services Task Force (USPSTF).										
Task Step 1…Utilize the clinical sub-committee to outline evidence-based protocols utilizing existing practices or industry standard for elevated cholesterol & hypertension.										
Task Step 2…Provide educational opportunities for partners by SME's with knowledge of NCEP or USPSTF to ensure informed decisions of the protocols.										
Task Step 3…Present evidence-based protocols to the Clinical Integration Committee for review & approval.										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
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 in place.										
Task Step 1…Utilize previously completed partner survey team members, strengths and best practice .										
Task Step 2.. The team to agree upon a screen tool to identify high risk cardiac patient and standardized best practice guidelines establish care coordination and goals and recommendation.										
Task Step 3… Present best practice to the Clinical Integration & Quality Committee for approval.										
Task Step 4… Publish and distribute best practice and expectations of the partners.										
Task Step 5… Implement the PPS best practice utilizing the PMO clinical staff as an implementation resource.										

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Task Step 6…Update IT platforms to ensuring formatting of the updated & approved best practice form.										
Task Step 7… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.										
Task Step 8.. Report quarterly to the clinical sub-committee for reviews of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	0	0	0	0	8	18	30	45	63	83
Task Step 1…Clinical sub-committee to establish a PPS best practice for access points for engaged patients to receive BP checks.										
Task Step 2…Outline workforce need for BP access points.										
Task Step 3…Document & communicate BP access point best practice expectations to all partners.										
Task Step 4... PPS staff to communicate to high risk patients, i.e. patients with hypertension, ability to have blood pressure check without an appointment										
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 Step 1…Clinical sub-committee to establish expectations of process of blood pressure monitoring & equipment needs to ensure PPS consistency.										
Task Step 2…PPS partners to identify training needs of staff/providers										

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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
related to BP measurements.										
Task Step 3…Provide educational opportunities to staff related to BP measurements.										
Task Step 4... Ensure office scheduling scheduling is completed that blood pressure checks can be completed without appointments as needed										
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 Step 1…Clinical sub-committee to define parameters of 'hypertension' & outline the tool being utilized (AHA, etc.). Present the best practice to the Clinical Integration Committee for review & approval.										
Task Step 2…Clinical sub-committee to define the frequency of monitoring parameters of Step 1 defined 'hypertensive' patients to include monitoring expectations.										
Task Step 3…Ensure provider schedules are flexible to allow for proper appointment scheduling of undiagnosed hypertension patients.										
Task Step 4…Communicate best practice expectations & hypertension parameters to all partners; PMO clinical staff to work with clinics for the implementation of best practices.										
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										

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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
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										
Task Step 1…Clinical sub-committee to establish a PPS best practice for once-daily regimens or fixed dose combination pills.										
Task Step 2…Present best practice to the Clinical Integration Committee for review & approval.										
Task Step 3…Publish & communicate best practice; PMO clinical team to work with partners to implement best practices.										
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task Step 1…Clinical sub-committee to define self-management goal clinical expectations & outline IT expectations for tracking.										
Task Step 2…Ensure IT personnel input into process by invitations to each clinical sub-committee.										
Task Step 3…Communicate self-management expectations to all partners & ensure capability.										
Task Step 4…Define educational needs of staff / providers & establish educational opportunities.										
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										

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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
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.										
Task Step 1…Survey Home Care agencies to identify current clinical state for community based programs to include behavioral health options.										
Task Step 2…Clinical sub-committee to create best practice standards for referrals to ensure referral & follow-up of patients.										
Task Step 3…Present best practice to the Clinical Integration Committee for review & approval.										
Task Step 4…Communicate best practice expectations to all partners; PMO clinical staff to become a resource for implementation.										
Task Step 5…Establish relationships with providers & community based resource options.										
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.										
Task PPS has developed and implemented protocols for home blood pressure monitoring.										
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.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Step 1…PMO to request Home Care best practices currently in use to outline current clinical practice.										
Task Step 2…Clinical sub-committee to review all current practices & identify PPS protocol for home blood pressure monitoring.										
Task Step 3…Present best practice to the Clinical Integration Committee for review & approval.										

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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
Task Step 4…Communicate best practice expectations to all partners; PMO clinical staff to become a resource for implementation.										
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task Step 1…Utilize EMR registry options track engaged patients & utilization of follow-up care.										
Task Step 2…Define parameters of expectations of follow-up care utilizing the clinical sub-committee.										
Task Step 3…Create an automated scheduling process of patients in the registry that do not meet the parameters of follow-up.										
Task Step 4…Create a reporting expectation of the EMR patient registry with metrics & parameters.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task Step 1…Ensure all partners have information for referrals to the NYS Smoker's Quitline through an educational presentation to the clinical sub-committee.										
Task Step 2…Facilitate ongoing dialogue regarding complexities or issues identified with the referral process utilizing the clinical sub-committee.										
Task Step 3…Utilize the NYS provider education program to provider & staff education specific to the NYS Quitline.										
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.										

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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
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.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task Step 1…PMO clinical rapid response team will identify "hot spotting" expectations focused to cardiovascular disease & utilize PMO staff to complete necessary reports of REAL information as deemed by the PMO or need of the clinical sub-committee.										
Task Step 2…Information obtained by the PMO will be shared with the clinical sub-committee based on outcomes.										
Task Step 3..Clinical sub-committee will make recommendations for programmatic changes based on input & outcomes of the existing program.										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	20	35	65	85	105	131	131	131
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	5	15	27	39	46	50	50	50
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	0	0	0	0	1
Task Step 1…Allow informational presentation of the Million Hearts Campaign to the clinical sub-committee to ensure full involvement.										
Task Step 2…Clinical sub-committee to outline strategies appropriate to the PPS engaged patient population & create PPS wide										

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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
expectations of strategy use.										
Task Step 3…Document & communicate the Million Hearts Campaign strategies to all partners.										
Task Step 4…Create a staff education model, if needed, for MHC strategies.										
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.										
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.										
Task Step 1…Survey partners to identify current clinical practices and uncovered services related to the cardiology program.										
Task Step 2…Identify areas of best practice that have impacted the patient population with cost reduction or quality indicator improvements to create a PPS improvement listing.										
Task Step 3…Engage MCD MCO organizations in each clinical sub-committee to ensure full understanding of processes & projects.										
Task Step 4…PMO to analyze quality & payer-data to identify negotiation potentials, strengths, and weaknesses.										
Task Step 5…PMO to communicate the findings in Step 4 to all partners involved for individual MCO negotiations.										
Task Step 6…Requirement will be loaded into Performance Logic for quarterly updates from all partners.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	0	20	35	65	85	105	131	131	131
Task Step 1…Define PCP's in PPS network according to the NYS										

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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
published network listing & communicate to the clinical sub-committee.										
Task Step 2…Ensure all PCP's outlined above are invited to clinical sub-committee meetings.										
Task Step 3..Complete partner agreements for partners involved in the project with details of expectations of deliverables.										
Task Step 4…Utilize PMO clinical staff to follow-up with unengaged partners to meet the 80% expectation.										
Task Step 5…Continue to network with providers in the community in order to maximize provider network during allotted NYS enrollment periods.										

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
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task Step 1…Utilize the clinical sub-committee to outline evidence-based strategies utilizing existing practices or industry standards.										
Task Step 2…Present evidence-based strategies to the Clinical Integration Committee for review & approval.										
Task Step 3…Create a roll-out schedule with defined risks including all partners involved.										
Task Step 4…Establish reporting expectations of partners for outlined indicators that relate to the evidence-based strategies to monitor quarterly to show outcomes. Utilize the PMO clinical team as a resource to track/trend/interpret the reports in order to suggest changes.										
Task Step 5…Present reports to the clinical sub-committee for input										

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into program based on outcomes.										
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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	45	47	47	47	47	47	47	47	47	47
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	15	17	17	17	17	17	17	17	17	17
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task PPS uses alerts and secure messaging functionality.										
Task Step 1…Utilize survey of all partners outlined in the IT Implementation Plan to establish current IT state to include EHR usage, and RHIO access.										
Task Step 2…Identify gaps of electronic health record use or RHIO involvement from the survey and discuss needs with PPS partners.										
Task Step 3…Create a roll-out schedule for those committed partners identified in the gap assessment to move to an EHR or RHIO use for access to electronic health records.										
Task Step 4…Provide funding information & options to paper based providers to help assist with financial needs of EMR implementation.										
Task Step 5…Present the roll-out schedule to the IT Committee for review & final recommendation for approval to the Clinical Integration Committee for the initiation of implementation.										
Task Step 6…Include the roll-out schedule in Performance Logic (PMO Tool) to outline timing & expectations for progress to be tracked & input by partners. Information will be used for progress reports and PPS dashboards to ensure timely completion.										

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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.										
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.	106	131	131	131	131	131	131	131	131	131
Task Step 1…Utilize the IT survey outlined in the Organization Implementation Plan to identify partners with no EHR or EHR's that do not meet Meaning Use expectations.										
Task Step 2…Follow the plan outlined in the IT Implementation Plan to identify a road map & timing to close the gap for non-EHR use or MU inadequacies.										
Task Step 3…Provide ongoing feedback to the clinical sub-committee regarding connectivity or issues identified.										
Task Step 4…Provide feedback to the clinical sub-committee as to IT expectations & progress.										
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 Step 1…Communicate & discuss the definition of 'DSRIP engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task										

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Step 4…Document processed(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										
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 Step 1…Provide education to the PPS partners of the 5 A's by inviting a SME to the clinical sub-committee and ensure the inclusion of an IT representative for proper tracking.										
Task Step 2…Establish current tracking processes of all partners for the 5 A's; document & identify gaps.										
Task Step 3…Create a plan for an automated scheduling system to facilitate tobacco control protocols.										
Task Step 4…Provide monthly/quarterly updates to the clinical sub-committee.										
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 Step 1…Utilize the clinical sub-committee to outline evidence-based protocols utilizing existing practices or industry standard for elevated cholesterol & hypertension.										
Task Step 2…Provide educational opportunities for partners by SME's with knowledge of NCEP or USPSTF to ensure informed decisions of the protocols.										

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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 Step 3…Present evidence-based protocols to the Clinical Integration Committee for review & approval.										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
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 in place.										
Task Step 1…Utilize previously completed partner survey team members, strengths and best practice .										
Task Step 2.. The team to agree upon a screen tool to identify high risk cardiac patient and standardized best practice guidelines establish care coordination and goals and recommendation.										
Task Step 3… Present best practice to the Clinical Integration & Quality Committee for approval.										
Task Step 4… Publish and distribute best practice and expectations of the partners.										
Task Step 5… Implement the PPS best practice utilizing the PMO clinical staff as an implementation resource.										
Task Step 6…Update IT platforms to ensuring formatting of the updated & approved best practice form.										
Task Step 7… Establish reporting expectations to review the performance of the best practices implemented to include reporting tools, timing and accountability.										
Task Step 8.. Report quarterly to the clinical sub-committee for reviews										

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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
of the effectiveness of the standard. Adjustments will be presented to the Clinical Integration Committee for approval.										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	106	131	131	131	131	131	131	131	131	131
Task Step 1…Clinical sub-committee to establish a PPS best practice for access points for engaged patients to receive BP checks.										
Task Step 2…Outline workforce need for BP access points.										
Task Step 3…Document & communicate BP access point best practice expectations to all partners.										
Task Step 4... PPS staff to communicate to high risk patients, i.e. patients with hypertension, ability to have blood pressure check without an appointment										
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 Step 1…Clinical sub-committee to establish expectations of process of blood pressure monitoring & equipment needs to ensure PPS consistency.										
Task Step 2…PPS partners to identify training needs of staff/providers related to BP measurements.										
Task Step 3…Provide educational opportunities to staff related to BP measurements.										
Task Step 4... Ensure office scheduling scheduling is completed that blood pressure checks can be completed without appointments as needed										
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of										

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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
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 Step 1…Clinical sub-committee to define parameters of 'hypertension' & outline the tool being utilized (AHA, etc.). Present the best practice to the Clinical Integration Committee for review & approval.										
Task Step 2…Clinical sub-committee to define the frequency of monitoring parameters of Step 1 defined 'hypertensive' patients to include monitoring expectations.										
Task Step 3…Ensure provider schedules are flexible to allow for proper appointment scheduling of undiagnosed hypertension patients.										
Task Step 4…Communicate best practice expectations & hypertension parameters to all partners; PMO clinical staff to work with clinics for the implementation of best practices.										
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										
Task Step 1…Clinical sub-committee to establish a PPS best practice for once-daily regimens or fixed dose combination pills.										
Task Step 2…Present best practice to the Clinical Integration Committee for review & approval.										
Task Step 3…Publish & communicate best practice; PMO clinical team										

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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
to work with partners to implement best practices.										
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task Step 1…Clinical sub-committee to define self-management goal clinical expectations & outline IT expectations for tracking.										
Task Step 2…Ensure IT personnel input into process by invitations to each clinical sub-committee.										
Task Step 3…Communicate self-management expectations to all partners & ensure capability.										
Task Step 4…Define educational needs of staff / providers & establish educational opportunities.										
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.										
Task Step 1…Survey Home Care agencies to identify current clinical state for community based programs to include behavioral health options.										
Task Step 2…Clinical sub-committee to create best practice standards for referrals to ensure referral & follow-up of patients.										

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Task Step 3…Present best practice to the Clinical Integration Committee for review & approval.										
Task Step 4…Communicate best practice expectations to all partners; PMO clinical staff to become a resource for implementation.										
Task Step 5…Establish relationships with providers & community based resource options.										
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.										
Task PPS has developed and implemented protocols for home blood pressure monitoring.										
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.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Step 1…PMO to request Home Care best practices currently in use to outline current clinical practice.										
Task Step 2…Clinical sub-committee to review all current practices & identify PPS protocol for home blood pressure monitoring.										
Task Step 3…Present best practice to the Clinical Integration Committee for review & approval.										
Task Step 4…Communicate best practice expectations to all partners; PMO clinical staff to become a resource for implementation.										
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task Step 1…Utilize EMR registry options track engaged patients & utilization of follow-up care.										

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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 Step 2…Define parameters of expectations of follow-up care utilizing the clinical sub-committee.										
Task Step 3…Create an automated scheduling process of patients in the registry that do not meet the parameters of follow-up.										
Task Step 4…Create a reporting expectation of the EMR patient registry with metrics & parameters.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task Step 1…Ensure all partners have information for referrals to the NYS Smoker's Quitline through an educational presentation to the clinical sub-committee.										
Task Step 2…Facilitate ongoing dialogue regarding complexities or issues identified with the referral process utilizing the clinical sub-committee.										
Task Step 3…Utilize the NYS provider education program to provider & staff education specific to the NYS Quitline.										
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.										
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.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task Step 1…PMO clinical rapid response team will identify "hot										

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spotting" expectations focused to cardiovascular disease & utilize PMO staff to complete necessary reports of REAL information as deemed by the PMO or need of the clinical sub-committee.										
Task Step 2…Information obtained by the PMO will be shared with the clinical sub-committee based on outcomes.										
Task Step 3..Clinical sub-committee will make recommendations for programmatic changes based on input & outcomes of the existing program.										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	131	131	131	131	131	131	131	131	131	131
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	50	50	50	50	50	50	50	50	50	50
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	1	1	1	1	1	1	1	1	1	1
Task Step 1…Allow informational presentation of the Million Hearts Campaign to the clinical sub-committee to ensure full involvement.										
Task Step 2…Clinical sub-committee to outline strategies appropriate to the PPS engaged patient population & create PPS wide expectations of strategy use.										
Task Step 3…Document & communicate the Million Hearts Campaign strategies to all partners.										
Task Step 4…Create a staff education model, if needed, for MHC strategies.										
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.										
Task PPS has agreement in place with MCO related to coordination of										

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

DSRIP Implementation Plan Project

NewYork-Presbyterian/Queens (PPS ID:40)

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
services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task Step 1…Survey partners to identify current clinical practices and uncovered services related to the cardiology program.										
Task Step 2…Identify areas of best practice that have impacted the patient population with cost reduction or quality indicator improvements to create a PPS improvement listing.										
Task Step 3…Engage MCD MCO organizations in each clinical sub-committee to ensure full understanding of processes & projects.										
Task Step 4…PMO to analyze quality & payer-data to identify negotiation potentials, strengths, and weaknesses.										
Task Step 5…PMO to communicate the findings in Step 4 to all partners involved for individual MCO negotiations.										
Task Step 6…Requirement will be loaded into Performance Logic for quarterly updates from all partners.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	131	131	131	131	131	131	131	131	131	131
Task Step 1…Define PCP's in PPS network according to the NYS published network listing & communicate to the clinical sub-committee.										
Task Step 2…Ensure all PCP's outlined above are invited to clinical sub-committee meetings.										
Task Step 3..Complete partner agreements for partners involved in the project with details of expectations of deliverables.										
Task Step 4…Utilize PMO clinical staff to follow-up with unengaged partners to meet the 80% expectation.										
Task Step 5…Continue to network with providers in the community in order to maximize provider network during allotted NYS										

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enrollment periods.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Task 4 end date was changed to 3/31/16 to align with the roll out of the pop health management tool for the PPS
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.	
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.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	PPS has presented the 5A's to the committee and participating partners, Tasks 2-4 end dates have been adjusted to accommodate for the process of determining how to integrate this into the developing EHR/IT systems and ensure appropriate monitoring and implementation.
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	
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.	
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	
Document patient driven self-management goals in the medical record and review with patients at each visit.	
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	
Develop and implement protocols for home blood pressure monitoring with follow up support.	
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	
Facilitate referrals to NYS Smoker's Quitline.	
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.	
Adopt strategies from the Million Hearts Campaign.	
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	The PPS has delayed the completion of task 2 to 6/30/16 to align with efforts of the finance and VBP groups.
Engage a majority (at least 80%) of primary care providers in this project.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	Pass & Ongoing	
Milestone #18	Pass & Ongoing	
Milestone #19	Pass & Ongoing	
Milestone #20	Pass & Ongoing	

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IPQR Module 3.b.i.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 3.b.i.5 - IA Monitoring

Instructions :

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Project 3.d.ii – Expansion of asthma home-based self-management program

IPQR Module 3.d.ii.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.

Risk #1: The adherence to home based treatment regimens once determined by the PCP, non PCP, pulmonologists and other health care providers.

Mitigation #1: A population health management strategy will be developed using IT software that will be determined to best connect with the attributed patient population, to serve as a trigger for compliance, with medication reminders, appointment reminders, and general asthma health reinforcement. The tool will assist with patient tracking and planning, and serve as a component of a proposed Asthma Resource Center for care coordination. Alternative ways for monitoring for adherence, such as one way communication such as text reminders will help move the efforts already in place with the Pediatric Asthma Center to more all-inclusive care coordination with improved patient outcomes and better management of a home based program.

Risk #2: Interconnectivity with PPS school systems will be a concern and prove a risk to the successful achievement of milestones and metrics.

Mitigation #2: Electronic school based health records are in different stages of technology development and the connection to an Asthma Resource Center will have to be recognized by the PPS leads to ensure that pathways to share the Medication Administration Form (MAF) with providers to coordinate care for the children associated with the project. The plan is to develop coalitions, protocols, and best practice technology based platforms to enhance bidirectional transfer of information to best support this patient population.

Risk #3: The expansion project of asthma home-based self-management program is the ability for providers to gain access to conduct the initial environmental assessment for trigger identification and subsequent visits to monitor and adjust recommendations once triggers are identified. Financial reimbursement and lack of funding for these visits is a component and risk for this project also.

Mitigation #3: The preexisting Pediatric Asthma Center will serve as a model the PPS best practice, led by Dr. Jabbar, who will leverage existing collaborations among community organizations to ensure all CBO, including schools, shelters, housing representatives, and other organization are in alignment with risk modification once identified. The initiative will take preexisting best practice and expand to repeat visit needs to determine compliance with recommendations for home environment adjustments. The team is leveraging established asthma community based programs to support PCPs, non-PCPs and health care providers on evidence based practice guidelines to support home management, including repeat home visits when necessary with financial components/incentives.

Risk #4: Connection of the Asthma Resource Center and PPS partners through interoperable electronic medical records or RHIO.

Mitigation #4: IT Committee to work with clinical sub-committee to identify interoperability and access of RHIO by partners, ARC, and schools to

maximize communication & coordination of care.

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IPQR Module 3.d.ii.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	863

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
318	323	62.48%	194	37.43%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (517)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cc599179	Documentation/Certification	40_PMDL4715_1_3_20160202155736_NYPQ_Asthma_3.d.ii.xlsx	Asthma 3.d.ii patient engagement	02/02/2016 03:58 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 3.d.ii.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Project	N/A	In Progress	08/01/2015	08/01/2016	08/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.	Project		In Progress	08/01/2015	08/01/2016	08/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task Step 1…Create a clinical flow diagram, including all partner types, to include the dynamics of point-of-care activity - referral programs - CBO's - home based care - and DME processing to show the anticipated flow of a patient from point 'A' to 'Z' to ensure understanding & communication of program expectations to all partners utilizing the clinical sub-committee.	Project		Completed	08/01/2015	11/01/2015	08/01/2015	11/01/2015	12/31/2015	DY1 Q3
Task Step 2…Outline best practice standards, based on the above flow diagram, for the program to document PPS expectations. Best practices will include, but not limited to, management of medication, follow-up care, specialty care referrals, home care assessments & coordination, etc.	Project		In Progress	11/01/2015	01/01/2016	11/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 3…Review best practice standards & flow diagram with the Asthma Coalition & any other designated CBO's to ensure collaboration & involvement.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…Clinical sub-committee to present best practice standards to the Clinical Integration Committee to see input & approvals.	Project		Not Started	02/01/2016	04/01/2016	02/01/2016	04/01/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 5…Define partners involved by care outlined in clinical flow diagram & review operational needs for workforce, IT, and operational processes.	Project		Not Started	04/01/2016	07/01/2016	04/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 6…Utilizing the partner listing, clinical flow diagram, and best practice standards, define a timeline to align with the requirement deliverable date of DY3, Q4 as well as the expectations of scale & speed.	Project		Not Started	04/01/2016	07/01/2016	04/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 7…Partner with the Cultural Competency sub-committee to include cultural competency & health literacy processes in all aspects of home care.	Project		Not Started	05/01/2016	08/01/2016	05/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task Step 8…Utilize the Asthma Resource Center (ARC) to coordinate care for engaged patients.	Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Project	N/A	In Progress	12/01/2015	08/01/2016	12/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.	Project		In Progress	12/01/2015	08/01/2016	12/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task Step 1…Develop an Asthma Resource Center (ARC) to manage all care coordination and create asthma action plans for all patients.	Project		In Progress	12/01/2015	06/01/2016	12/01/2015	06/01/2016	06/30/2016	DY2 Q1
Task Step 2…Establish evidence-based interventions for the use of 'ARC' and home-care teams that focus to the reduction of triggers and care coordination.	Project		In Progress	12/01/2015	06/01/2016	12/01/2015	06/01/2016	06/30/2016	DY2 Q1
Task Step 3…Hire care coordinators to staff the 'ARC'; provide staff training; set expectations of coordination of care in accordance with best practice protocols outlined in Requirement #3.	Project		Not Started	02/01/2016	08/01/2016	02/01/2016	08/01/2016	09/30/2016	DY2 Q2

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Task Step 4…'ARC' to present to the clinical sub-committee quarterly as to the progress of the center, outcomes of care coordination, and challenges identified of best practice standards.	Project		Not Started	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task Step 5…PPS PMO clinical team will utilize data provided by the 'ARC' in the rapid cycle evaluation process.	Project		Not Started	04/01/2016	07/01/2016	04/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 6…Establish relationships with schools utilized by engaged patient population to allow for communication & education of teams.	Project		In Progress	12/01/2015	08/01/2016	12/01/2015	08/01/2016	09/30/2016	DY2 Q2
Task Step 7…Utilize CBO's to expand/create educational opportunities for patients & families regarding triggers.	Project		In Progress	12/01/2015	08/01/2016	12/01/2015	08/01/2016	09/30/2016	DY2 Q2
Milestone #3 Develop and implement evidence-based asthma management guidelines.	Project	N/A	In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.	Project		In Progress	08/01/2015	03/31/2017	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize the National Heart, Lung and Blood Institute's National Asthma Education and Prevention Program Guidelines Implementation Panel Report for EPR-3 to define the PPS best practice protocols. Ensure processes & protocols address utilization of nursing staff, pharmacists, dieticians & CHW's.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2…Review guidelines with the clinical sub-committee & the Asthma Coalition for revisions.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3…Present guidelines to the Clinical Integration Committee for revisions or approvals.	Project		Not Started	04/01/2016	06/01/2016	04/01/2016	06/01/2016	06/30/2016	DY2 Q1
Task Step 4…Publish & communicate guidelines to all committed partners.	Project		Not Started	06/01/2016	10/01/2016	06/01/2016	10/01/2016	12/31/2016	DY2 Q3
Task	Project		Not Started	08/01/2016	12/01/2016	08/01/2016	12/01/2016	12/31/2016	DY2 Q3

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Step 5…Establish a review process of the guidelines utilizing the 'ARC' and the rapid cycle staff of the PMO that reviews outcomes or struggles related to the guidelines.									
Task Step 6…Define non-covered services related to management guidelines to inform MCO conversations by PPS partners.	Project		Not Started	08/01/2016	03/31/2017	08/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7…Establish a staff & provider education program, housed in the 'ARC' but partnered with CBO's, Asthma Coalition, and social services, focused the expectations of the asthma program & evidence based guidelines. (Train the trainer program)	Project		In Progress	12/01/2015	05/01/2016	12/01/2015	05/01/2016	06/30/2016	DY2 Q1
Task Step 8…Create a feedback process in Performance Logic for partners to communicate with the PMO as the progress of the implementation of the asthma management guidelines & their effectiveness and training expectations and adoption of new/updated evidence based guidenelines as needed. PMO to provide quarterly reports to the clinical sub-committee.	Project		Not Started	06/01/2016	12/31/2016	06/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1... Ensure provider and staff are aware aware and/or trained to refer patients to the 'ARC' as clinically appropriate to receive continued self-management education and community/home care referrals. The ARC will work with the Asthma Coalition of Queens to educate providers of asthma self-management education using the NAEPP – EPR-3 Guidelines	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	09/01/2016	09/30/2016	DY2 Q2

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as a structure and delivered accordingly to each type of provider and from a variety of sources: PACE (Physician Asthma Care Education) from the NHLBI, Becoming an Asthma Educator Care Manager (Association of Asthma Educators (AAE)), Asthma Educator Institute (American Lung Association-course to prepare for the Asthma Educator Certification Test), Community Health Worker Asthma Education Training (AAE & NHLBI), etc.									
Task Step 2... Providers to create an asthma action plan as appropriate for asthma patients and referral to the 'ARC'	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3... 'ARC' to education patients and/or caregivers on common asthma environmental triggers and reduction opportunities, medications, , self-monitoring, and the importance of utilizing the action plan.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4..."ARC' to refer patient and/or caregiver to community resources, home care providers for home assessment, and/or PPS partners for air filters, inhalers, school prorams, etc. as appropriate. Patients who are referred to the asthma resource center will be stratified for levels of care, asthma self-management education and asthma home environmental assessment and remediation.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5... If there is an ED or IP incident, refer the patient for a home assessment and complete a root cause analysis and update the asthma action plan if appropriate	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has developed and conducted training of all providers, including social services and support.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has assembled a care coordination team that includes use	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.									
Task Step 1…Ensure the 'ARC' has access to IT platforms that allow for electronic communications/referrals/documentation of care coordination.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 2…Include representatives of social services, pharmacists, dietitians & CHW's on the clinical sub-committee to allow for ongoing inputs and clinical updates from the ARC and other clinical personnel.	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3...'ARC' will refer patients to home care after an ED or IP incident for a RCA and update asthma action plan as appropriate	Project		In Progress	12/31/2015	12/31/2016	12/31/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Project	N/A	In Progress	08/01/2015	07/01/2016	08/01/2015	07/01/2016	09/30/2016	DY2 Q2
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.	Project		In Progress	08/01/2015	07/01/2016	08/01/2015	07/01/2016	09/30/2016	DY2 Q2
Task Step 1…Utilize a population health management IT platform to track engaged patients ED & hospital usage.	Project		In Progress	08/01/2015	04/01/2016	08/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Step 2…Define expectations of use & reporting of the population health management tool to include monthly & quarterly reports.	Project		In Progress	08/01/2015	04/01/2016	08/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Step 3…Rapid cycle evaluation PMO team partners with the 'ARC' and partners to establish parameters focused to ED & hospital utilization that outline follow-up processes after occurrence.	Project		In Progress	12/01/2015	04/01/2016	12/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task Step 4…Data collected with the population health management tool will be reported to the clinical sub-committee for review &	Project		Not Started	03/01/2016	07/01/2016	03/01/2016	07/01/2016	09/30/2016	DY2 Q2

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recommendations for programmatic changes.									
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Project	N/A	In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.	Project		In Progress	08/01/2015	03/31/2018	08/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Ensure clinical sub-committee is a proper representation of partners to include primary & specialty care providers, health home care managers, social services, coalitions, etc.	Project		Completed	08/01/2015	12/01/2015	08/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 2…Clinical sub-committee to meet monthly or quarterly based on the needs of the clinical development, at the discretion of the chair.	Project		Completed	09/01/2015	12/01/2015	09/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…Utilize all steps outlined in the Project Implementation Plan to inform provider agreements & edit as needed for asthma program.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Share information gathered during guideline development for partners to negotiate MCO agreements for non-covered services.	Project		In Progress	09/01/2015	03/31/2018	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

NewYork-Presbyterian/Queens (PPS ID:40)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Document process(s) by partner of tracking engaged patients.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.										
Task Step 1…Create a clinical flow diagram, including all partner types, to include the dynamics of point-of-care activity - referral programs - CBO's - home based care - and DME processing to show the anticipated flow of a patient from point 'A' to 'Z' to ensure understanding & communication of program expectations to all partners utilizing the clinical sub-committee.										
Task Step 2…Outline best practice standards, based on the above flow diagram, for the program to document PPS expectations. Best practices will include, but not limited to, management of medication, follow-up care, specialty care referrals, home care assessments & coordination, etc.										
Task Step 3…Review best practice standards & flow diagram with the										

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DSRIP Implementation Plan Project

NewYork-Presbyterian/Queens (PPS ID:40)

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
Asthma Coalition & any other designated CBO's to ensure collaboration & involvement.										
Task Step 4…Clinical sub-committee to present best practice standards to the Clinical Integration Committee to see input & approvals.										
Task Step 5…Define partners involved by care outlined in clinical flow diagram & review operational needs for workforce, IT, and operational processes.										
Task Step 6…Utilizing the partner listing, clinical flow diagram, and best practice standards, define a timeline to align with the requirement deliverable date of DY3, Q4 as well as the expectations of scale & speed.										
Task Step 7…Partner with the Cultural Competency sub-committee to include cultural competency & health literacy processes in all aspects of home care.										
Task Step 8…Utilize the Asthma Resource Center (ARC) to coordinate care for engaged patients.										
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.										
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										
Task Step 1…Develop an Asthma Resource Center (ARC) to manage all care coordination and create asthma action plans for all patients.										
Task Step 2…Establish evidence-based interventions for the use of 'ARC' and home-care teams that focus to the reduction of triggers and care coordination.										
Task Step 3…Hire care coordinators to staff the 'ARC'; provide staff training; set expectations of coordination of care in accordance										

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NewYork-Presbyterian/Queens (PPS ID:40)

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
with best practice protocols outlined in Requirement #3.										
Task Step 4…'ARC' to present to the clinical sub-committee quarterly as to the progress of the center, outcomes of care coordination, and challenges identified of best practice standards.										
Task Step 5…PPS PMO clinical team will utilize data provided by the 'ARC' in the rapid cycle evaluation process.										
Task Step 6…Establish relationships with schools utilized by engaged patient population to allow for communication & education of teams.										
Task Step 7…Utilize CBO's to expand/create educational opportunities for patients & families regarding triggers.										
Milestone #3 Develop and implement evidence-based asthma management guidelines.										
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
Task Step 1…Utilize the National Heart, Lung and Blood Institute's National Asthma Education and Prevention Program Guidelines Implementation Panel Report for EPR-3 to define the PPS best practice protocols. Ensure processes & protocols address utilization of nursing staff, pharmacists, dieticians & CHW's.										
Task Step 2…Review guidelines with the clinical sub-committee & the Asthma Coalition for revisions.										
Task Step 3…Present guidelines to the Clinical Integration Committee for revisions or approvals.										
Task Step 4…Publish & communicate guidelines to all committed partners.										
Task Step 5…Establish a review process of the guidelines utilizing the 'ARC' and the rapid cycle staff of the PMO that reviews outcomes or struggles related to the guidelines.										

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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
Task Step 6…Define non-covered services related to management guidelines to inform MCO conversations by PPS partners.										
Task Step 7…Establish a staff & provider education program, housed in the 'ARC' but partnered with CBO's, Asthma Coalition, and social services, focused the expectations of the asthma program & evidence based guidelines. (Train the trainer program)										
Task Step 8…Create a feedback process in Performance Logic for partners to communicate with the PMO as the progress of the implementation of the asthma management guidelines & their effectiveness and training expectations and adoption of new/updated evidence based guidenelines as needed. PMO to provide quarterly reports to the clinical sub-committee.										
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task Step 1... Ensure provider and staff are aware aware and/or trained to refer patients to the 'ARC' as clinically appropriate to receive continued self-management education and community/home care referrals. The ARC will work with the Asthma Coalition of Queens to educate providers of asthma self-management education using the NAEPP – EPR-3 Guidelines as a structure and delivered accordingly to each type of provider and from a variety of sources: PACE (Physician Asthma Care Education) from the NHLBI, Becoming an Asthma Educator Care Manager (Association of Asthma Educators (AAE)), Asthma Educator Institute (American Lung Association-course to prepare for the Asthma Educator Certification Test), Community Health Worker Asthma Education Training (AAE & NHLBI), etc.										
Task Step 2... Providers to create an asthma action plan as										

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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
appropriate for asthma patients and referral to the 'ARC'										
Task Step 3... 'ARC' to education patients and/or caregivers on common asthma environmental triggers and reduction opportunities, medications, , self-monitoring, and the importance of utilizing the action plan.										
Task Step 4..."ARC' to refer patient and/or caregiver to community resources, home care providers for home assessment, and/or PPS partners for air filters, inhalers, school prorams, etc. as appropriate. Patients who are referred to the asthma resource center will be stratified for levels of care, asthma self-management education and asthma home environmental assessment and remediation.										
Task Step 5... If there is an ED or IP incident, refer the patient for a home assessment and complete a root cause analysis and update the asthma action plan if appropriate										
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.										
Task PPS has developed and conducted training of all providers, including social services and support.										
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.										
Task PPS has assembled a care coordination team that includes 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.										
Task Step 1…Ensure the 'ARC' has access to IT platforms that allow for electronic communications/referrals/documentation of care coordination.										
Task Step 2…Include representatives of social services, pharmacists, dietitians & CHW's on the clinical sub-committee to allow for ongoing inputs and clinical updates from the ARC and other clinical personnel.										
Task										

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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
Step 3...'ARC' will refer patients to home care after an ED or IP incident for a RCA and update asthma action plan as appropriate										
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.										
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.										
Task Step 1…Utilize a population health management IT platform to track engaged patients ED & hospital usage.										
Task Step 2…Define expectations of use & reporting of the population health management tool to include monthly & quarterly reports.										
Task Step 3…Rapid cycle evaluation PMO team partners with the 'ARC' and partners to establish parameters focused to ED & hospital utilization that outline follow-up processes after occurrence.										
Task Step 4…Data collected with the population health management tool will be reported to the clinical sub-committee for review & recommendations for programmatic changes.										
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Step 1…Ensure clinical sub-committee is a proper representation of partners to include primary & specialty care providers, health home care managers, social services, coalitions, etc.										
Task Step 2…Clinical sub-committee to meet monthly or quarterly based on the needs of the clinical development, at the discretion of the chair.										
Task										

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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
Step 3…Utilize all steps outlined in the Project Implementation Plan to inform provider agreements & edit as needed for asthma program.										
Task Step 4…Share information gathered during guideline development for partners to negotiate MCO agreements for non-covered services.										
Milestone #8 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 Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										

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
Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.										

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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 Step 1…Create a clinical flow diagram, including all partner types, to include the dynamics of point-of-care activity - referral programs - CBO's - home based care - and DME processing to show the anticipated flow of a patient from point 'A' to 'Z' to ensure understanding & communication of program expectations to all partners utilizing the clinical sub-committee.										
Task Step 2…Outline best practice standards, based on the above flow diagram, for the program to document PPS expectations. Best practices will include, but not limited to, management of medication, follow-up care, specialty care referrals, home care assessments & coordination, etc.										
Task Step 3…Review best practice standards & flow diagram with the Asthma Coalition & any other designated CBO's to ensure collaboration & involvement.										
Task Step 4…Clinical sub-committee to present best practice standards to the Clinical Integration Committee to see input & approvals.										
Task Step 5…Define partners involved by care outlined in clinical flow diagram & review operational needs for workforce, IT, and operational processes.										
Task Step 6…Utilizing the partner listing, clinical flow diagram, and best practice standards, define a timeline to align with the requirement deliverable date of DY3, Q4 as well as the expectations of scale & speed.										
Task Step 7…Partner with the Cultural Competency sub-committee to include cultural competency & health literacy processes in all aspects of home care.										
Task Step 8…Utilize the Asthma Resource Center (ARC) to coordinate care for engaged patients.										
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.										

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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 PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										
Task Step 1…Develop an Asthma Resource Center (ARC) to manage all care coordination and create asthma action plans for all patients.										
Task Step 2…Establish evidence-based interventions for the use of 'ARC' and home-care teams that focus to the reduction of triggers and care coordination.										
Task Step 3…Hire care coordinators to staff the 'ARC'; provide staff training; set expectations of coordination of care in accordance with best practice protocols outlined in Requirement #3.										
Task Step 4…'ARC' to present to the clinical sub-committee quarterly as to the progress of the center, outcomes of care coordination, and challenges identified of best practice standards.										
Task Step 5…PPS PMO clinical team will utilize data provided by the 'ARC' in the rapid cycle evaluation process.										
Task Step 6…Establish relationships with schools utilized by engaged patient population to allow for communication & education of teams.										
Task Step 7…Utilize CBO's to expand/create educational opportunities for patients & families regarding triggers.										
Milestone #3 Develop and implement evidence-based asthma management guidelines.										
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
Task Step 1…Utilize the National Heart, Lung and Blood Institute's National Asthma Education and Prevention Program Guidelines Implementation Panel Report for EPR-3 to define the PPS best practice protocols. Ensure processes & protocols address utilization of nursing staff, pharmacists, dieticians & CHW's.										

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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 Step 2…Review guidelines with the clinical sub-committee & the Asthma Coalition for revisions.										
Task Step 3…Present guidelines to the Clinical Integration Committee for revisions or approvals.										
Task Step 4…Publish & communicate guidelines to all committed partners.										
Task Step 5…Establish a review process of the guidelines utilizing the 'ARC' and the rapid cycle staff of the PMO that reviews outcomes or struggles related to the guidelines.										
Task Step 6…Define non-covered services related to management guidelines to inform MCO conversations by PPS partners.										
Task Step 7…Establish a staff & provider education program, housed in the 'ARC' but partnered with CBO's, Asthma Coalition, and social services, focused the expectations of the asthma program & evidence based guidelines. (Train the trainer program)										
Task Step 8…Create a feedback process in Performance Logic for partners to communicate with the PMO as the progress of the implementation of the asthma management guidelines & their effectiveness and training expectations and adoption of new/updated evidence based guidenelines as needed. PMO to provide quarterly reports to the clinical sub-committee.										
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task Step 1... Ensure provider and staff are aware aware and/or trained to refer patients to the 'ARC' as clinically appropriate to										

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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
receive continued self-management education and community/home care referrals. The ARC will work with the Asthma Coalition of Queens to educate providers of asthma self-management education using the NAEPP – EPR-3 Guidelines as a structure and delivered accordingly to each type of provider and from a variety of sources: PACE (Physician Asthma Care Education) from the NHLBI, Becoming an Asthma Educator Care Manager (Association of Asthma Educators (AAE)), Asthma Educator Institute (American Lung Association-course to prepare for the Asthma Educator Certification Test), Community Health Worker Asthma Education Training (AAE & NHLBI), etc.										
Task Step 2... Providers to create an asthma action plan as appropriate for asthma patients and referral to the 'ARC'										
Task Step 3... 'ARC' to education patients and/or caregivers on common asthma environmental triggers and reduction opportunities, medications, , self-monitoring, and the importance of utilizing the action plan.										
Task Step 4..."ARC' to refer patient and/or caregiver to community resources, home care providers for home assessment, and/or PPS partners for air filters, inhalers, school prorams, etc. as appropriate. Patients who are referred to the asthma resource center will be stratified for levels of care, asthma self-management education and asthma home environmental assessment and remediation.										
Task Step 5... If there is an ED or IP incident, refer the patient for a home assessment and complete a root cause analysis and update the asthma action plan if appropriate										
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.										
Task PPS has developed and conducted training of all providers, including social services and support.										
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.										
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence,										

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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
health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Step 1…Ensure the 'ARC' has access to IT platforms that allow for electronic communications/referrals/documentation of care coordination.										
Task Step 2…Include representatives of social services, pharmacists, dietitians & CHW's on the clinical sub-committee to allow for ongoing inputs and clinical updates from the ARC and other clinical personnel.										
Task Step 3...'ARC' will refer patients to home care after an ED or IP incident for a RCA and update asthma action plan as appropriate										
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.										
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.										
Task Step 1…Utilize a population health management IT platform to track engaged patients ED & hospital usage.										
Task Step 2…Define expectations of use & reporting of the population health management tool to include monthly & quarterly reports.										
Task Step 3…Rapid cycle evaluation PMO team partners with the 'ARC' and partners to establish parameters focused to ED & hospital utilization that outline follow-up processes after occurrence.										
Task Step 4…Data collected with the population health management tool will be reported to the clinical sub-committee for review & recommendations for programmatic changes.										
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has										

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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
established agreements with health home care managers, PCPs, and specialty providers.										
Task Step 1…Ensure clinical sub-committee is a proper representation of partners to include primary & specialty care providers, health home care managers, social services, coalitions, etc.										
Task Step 2…Clinical sub-committee to meet monthly or quarterly based on the needs of the clinical development, at the discretion of the chair.										
Task Step 3…Utilize all steps outlined in the Project Implementation Plan to inform provider agreements & edit as needed for asthma program.										
Task Step 4…Share information gathered during guideline development for partners to negotiate MCO agreements for non-covered services.										
Milestone #8 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 Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security.										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	
Develop and implement evidence-based asthma management guidelines.	
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Task 1 end date changed to 9/1/16 as ARC is in the process of being constructed and education for referrals will begin in tandem with ARC roll out
Ensure coordinated care for asthma patients includes social services and support.	
Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	

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IPQR Module 3.d.ii.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 3.d.ii.5 - IA Monitoring

Instructions :

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

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NewYork-Presbyterian/Queens (PPS ID:40)

Project 3.g.ii – Integration of palliative care into nursing homes

IPQR Module 3.g.ii.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.

Risk #1: Low provider and patient/family participation related to a culturally prominent aversion of care givers, patients and families to the topic of death and dying.

Mitigation #1: For the providers, the PPS and affiliates need to develop training sessions for providers and caregivers to understand the purpose of palliative care services and learn care giving behaviors and language that respects patient / families wishes. As part of the training sessions, the nursing homes have to consider the needs of the workforce to attend trainings, develop compliance tracking tools on educational sessions and incorporate training into mandatory and/or annual updates to be fully effective and have the most impact for the patients that they serve.

Risk #2: Low physician participation due to lack of reimbursement for palliative care services in the acute and/or inpatient setting due to the amount of time spent with patients and families focused to the education of palliative care & options.

Mitigation #2: Mitigation strategy would be to create expectations for all staff in contact with a palliative care patient to educate patients and families about palliative care options throughout the time of care to prepare the patient and family for the physician and create an efficient process with many communicators.

Risk #3: Low patient engagement due to religious and cultural beliefs about death and dying.

Mitigation #3: Strategies would include linking this with Cultural Competency/Health Literacy Link implementation plan to increase provider ability to treat this patient population in a culturally-sensitive manner. Incorporate training to providers, care givers, and palliative care coaches about beliefs for the predominant cultures in the service area, reflecting all levels of palliative care, including but not limited to fluid, feedings, transfer and other prominent components of the MOLST initiative.

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IPQR Module 3.g.ii.2 - Patient Engagement Speed

Instructions :

Enter the number of patients actively engaged through the current quarter. The number entered into the "Patient Update" area needs to reflect the cumulative method of counting within a DSRIP year. For example, the number reported in this field for DY1 Q3 should include patients previously reported in DY1 Q2 plus new patients engaged in DY1 Q3. Any explanations regarding altered or missed patient commitments must be included within the narrative box, not as text within uploaded documentation.

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	518

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
437	768	297.67%	-510	148.26%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
cc599179	Documentation/Certification	40_PMDL5215_1_3_20160202155938_NYPQ_Palliative_3.g.ii.xlsx	Palliative 3.g.ii patient engagement	02/02/2016 03:59 PM

Narrative Text :

For PPS to provide additional context regarding progress and/or updates to IA.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 3.g.ii.3 - Prescribed Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for prescribed milestones. For milestones that are due and completed within the reporting period, documentation is required to provide evidence of project requirement achievement. Any explanations regarding altered or missed provider commitments should be included within the narrative box, not as text within uploaded documentation.

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Integrate Palliative Care into practice model of participating Nursing Homes.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has integrated palliative care into Nursing Homes in alignment with project requirements.	Provider	Nursing Home	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has integrated palliative care into Nursing Homes in alignment with project requirements.	Provider	Hospice	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1…Identify providers participating in the project including SNF, hospice, and primary care physicians.	Project		Completed	07/01/2015	11/30/2015	07/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Step 2…Complete a current state assessment of palliative care services in participating sites.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 3…Utilize the current state assessment to complete a gap analysis and determine needs which may include workforce, IT, and training/education.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4…Determine schedule for roll-out of implementation and integration of clinical guidelines into participating sites.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5…Create and educational program for staff on role-appropriate palliative care services.	Project		In Progress	11/01/2015	02/01/2016	11/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 6… Implement clinical guidelines and processes into participating sites focused to standardization of basic parameters that allows for individual partner customization based on operational/patient needs.	Project		Not Started	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 7…Quarterly reports will be provided to the clinical sub-committee for clinical reviews of the effectiveness of the standard. Adjustments will be recommended based on outcomes & team feedback. All revisions will be presented to the Clinical Integration Committee for approval.	Project		Not Started	01/01/2016	07/01/2016	01/01/2016	07/01/2016	09/30/2016	DY2 Q2
Milestone #2 Contract or develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the nursing home.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the nursing home.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Identify community providers and resources that provide palliative care services in nursing homes.	Project		Completed	07/01/2015	11/30/2015	07/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Step 2…Consider collaboration opportunities with neighboring PPSs participating in this project.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3… Present recommendations for community and provider resource collaboration to the Clinical Integration and Executive Committees for approval to formalize partnerships as appropriate.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4… Formalize partnerships with community resources, which may include but are not limited to, provider agreement, BAA, MOUs.	Project		In Progress	10/01/2015	01/31/2016	10/01/2015	01/31/2016	03/31/2016	DY1 Q4
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Step 1…Identify nationally recognized clinical guidelines (i.e. Center for Advanced Palliative Care, CAPC) and PPS partner best practices to be adopted by the PPS at participating sites									
Task Step 2... Determine the number of participating providers that current utilize MOLST vs. eMOLST forms.	Project		Completed	07/01/2015	11/15/2015	07/01/2015	11/15/2015	12/31/2015	DY1 Q3
Task Step 3…Project sub-committee to develop clinical guidelines for palliative care services with clinical input from participating sites.	Project		In Progress	10/01/2015	01/31/2016	10/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task Step 4… Create an education program on the clinical guidelines for palliative care services for staff at participating sites.	Project		In Progress	11/01/2015	02/01/2016	11/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 4…Submit clinical guidelines and educational program recommendations for palliative care services to the Clinical Integration Committee and Workforce Committee for approval.	Project		Not Started	02/01/2016	05/01/2016	02/01/2016	05/01/2016	06/30/2016	DY2 Q1
Task Step 5… Integrate clinical guidelines into participating sites.	Project		Not Started	05/01/2016	11/01/2016	05/01/2016	11/01/2016	12/31/2016	DY2 Q3
Task Step 6… Quarterly reports will be provided to the clinical sub-committee for clinical reviews of the effectiveness of the standard. Adjustments will be recommended based on outcomes & team feedback. All revisions will be presented to the Clinical Integration Committee for approval.	Project		Not Started	05/01/2016	10/01/2016	05/01/2016	10/01/2016	12/31/2016	DY2 Q3
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Utilize current state assessment to create a gap analysis of education and training needs of staff at participating sites.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2… Leverage nationally recognized training & education	Project		Not Started	02/01/2016	07/01/2016	02/01/2016	07/01/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
programs (i.e. CAPC) to train staff on palliative care services.									
Task Step 3…Create training/education program based on gap analysis to address the integration of palliative care services into the nursing home.	Project		Not Started	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1
Task Step 4… Create schedule for initial and maintenance training/education sessions.	Project		Not Started	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1
Task Step 5… Leverage a palliative care champion (i.e. certified/experienced MD, NP, LCSW) as a resource and on site training at participating SNFs.	Project		Not Started	01/01/2016	04/01/2016	01/01/2016	04/01/2016	06/30/2016	DY2 Q1
Task Step 6.. Leverage hospice lead in-service sessions at SNFs to increase knowledge of role-appropriate palliative care services and resources available.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 7…Track staff participation in training through PMO project management software.	Project		Not Started	01/01/2016	08/01/2016	01/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task Step 8…Quarterly reports will be provided to the clinical sub-committee for clinical reviews of the effectiveness of the standard. Adjustments will be recommended based on outcomes & team feedback. All revisions will be presented to the Clinical Integration Committee for approval.	Project		Not Started	01/01/2016	08/01/2016	01/01/2016	08/01/2016	09/30/2016	DY2 Q2
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Identify uncovered palliative care services that are essential to the success of the project and improving the quality of patient care.	Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2…Present uncovered services recommendations to the Finance Committee and the Value Based Purchasing (VBP) sub-	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
committee.									
Task Step 3…Invite MCO representatives to clinical sub-committees to educate them of the PPS project, process, and improvements.	Project		Not Started	02/01/2016	07/01/2016	02/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 4…PMO executive leadership to partner with legal teams to outline the parameters of MCO negotiations to provide feedback to partners of next steps.	Project		Not Started	03/01/2016	07/01/2016	03/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task Step 5…PMO to publish recommendations, compliant to Step 4 discussions, for PPS partners to approach MCO partners for negotiations of uncovered services for palliative care.	Project		Not Started	07/01/2016	10/01/2016	07/01/2016	10/01/2016	12/31/2016	DY2 Q3
Task Step 6…Performance Logic will be loaded with the expectation of negotiations and providers will provide monthly progress updates.	Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security. (EHR Patient Registries, Amalgam Population Health, Allscripts Care Director)	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4…Document process(s) by partner of tracking engaged patients.	Project		Completed	10/01/2015	12/01/2015	10/01/2015	12/01/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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 Integrate Palliative Care into practice model of participating Nursing Homes.										
Task PPS has integrated palliative care into Nursing Homes in alignment with project requirements.	0	0	0	0	0	2	4	6	8	14
Task PPS has integrated palliative care into Nursing Homes in alignment with project requirements.	0	0	0	0	0	1	1	2	3	4
Task Step 1…Identify providers participating in the project including SNF, hospice, and primary care physicians.										
Task Step 2…Complete a current state assessment of palliative care services in participating sites.										
Task Step 3…Utilize the current state assessment to complete a gap analysis and determine needs which may include workforce, IT, and training/education.										
Task Step 4…Determine schedule for roll-out of implementation and integration of clinical guidelines into participating sites.										
Task Step 5…Create and educational program for staff on role-appropriate palliative care services.										
Task Step 6… Implement clinical guidelines and processes into participating sites focused to standardization of basic parameters that allows for individual partner customization based on operational/patient needs.										
Task Step 7…Quarterly reports will be provided to the clinical sub-committee for clinical reviews of the effectiveness of the										

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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
standard. Adjustments will be recommended based on outcomes & team feedback. All revisions will be presented to the Clinical Integration Committee for approval.										
Milestone #2 Contract or develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the nursing home.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the nursing home.										
Task Step 1…Identify community providers and resources that provide palliative care services in nursing homes.										
Task Step 2…Consider collaboration opportunities with neighboring PPSs participating in this project.										
Task Step 3… Present recommendations for community and provider resource collaboration to the Clinical Integration and Executive Committees for approval to formalize partnerships as appropriate.										
Task Step 4… Formalize partnerships with community resources, which may include but are not limited to, provider agreement, BAA, MOUs.										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form.										
Task Step 1…Identify nationally recognized clinical guidelines (i.e. Center for Advanced Palliative Care, CAPC) and PPS partner best practices to be adopted by the PPS at participating sites										
Task Step 2... Determine the number of participating providers that current utilize MOLST vs. eMOLST forms.										
Task Step 3…Project sub-committee to develop clinical guidelines for palliative care services with clinical input from participating sites.										

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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
Task Step 4… Create an education program on the clinical guidelines for palliative care services for staff at participating sites.										
Task Step 4…Submit clinical guidelines and educational program recommendations for palliative care services to the Clinical Integration Committee and Workforce Committee for approval.										
Task Step 5… Integrate clinical guidelines into participating sites.										
Task Step 6… Quarterly reports will be provided to the clinical sub-committee for clinical reviews of the effectiveness of the standard. Adjustments will be recommended based on outcomes & team feedback. All revisions will be presented to the Clinical Integration Committee for approval.										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task Step 1…Utilize current state assessment to create a gap analysis of education and training needs of staff at participating sites.										
Task Step 2… Leverage nationally recognized training & education programs (i.e. CAPC) to train staff on palliative care services.										
Task Step 3…Create training/education program based on gap analysis to address the integration of palliative care services into the nursing home.										
Task Step 4… Create schedule for initial and maintenance training/education sessions.										
Task Step 5… Leverage a palliative care champion (i.e. certified/experienced MD, NP, LCSW) as a resource and on site training at participating SNFs.										
Task Step 6.. Leverage hospice lead in-service sessions at SNFs to increase knowledge of role-appropriate palliative care services and resources available.										

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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
Task Step 7…Track staff participation in training through PMO project management software.										
Task Step 8…Quarterly reports will be provided to the clinical sub-committee for clinical reviews of the effectiveness of the standard. Adjustments will be recommended based on outcomes & team feedback. All revisions will be presented to the Clinical Integration Committee for approval.										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task Step 1…Identify uncovered palliative care services that are essential to the success of the project and improving the quality of patient care.										
Task Step 2…Present uncovered services recommendations to the Finance Committee and the Value Based Purchasing (VBP) sub-committee.										
Task Step 3…Invite MCO representatives to clinical sub-committees to educate them of the PPS project, process, and improvements.										
Task Step 4…PMO executive leadership to partner with legal teams to outline the parameters of MCO negotiations to provide feedback to partners of next steps.										
Task Step 5…PMO to publish recommendations, compliant to Step 4 discussions, for PPS partners to approach MCO partners for negotiations of uncovered services for palliative care.										
Task Step 6…Performance Logic will be loaded with the expectation of negotiations and providers will provide monthly progress updates.										
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively										

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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
engaged patients for project milestone reporting.										
Task Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security. (EHR Patient Registries, Amalgam Population Health, Allscripts Care Director)										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										

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
Milestone #1 Integrate Palliative Care into practice model of participating Nursing Homes.										
Task PPS has integrated palliative care into Nursing Homes in alignment with project requirements.	19	27	27	27	27	27	27	27	27	27
Task PPS has integrated palliative care into Nursing Homes in alignment with project requirements.	5	6	6	6	6	6	6	6	6	6
Task Step 1…Identify providers participating in the project including SNF, hospice, and primary care physicians.										
Task Step 2…Complete a current state assessment of palliative care services in participating sites.										
Task Step 3…Utilize the current state assessment to complete a gap analysis and determine needs which may include workforce, IT, and training/education.										

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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 Step 4…Determine schedule for roll-out of implementation and integration of clinical guidelines into participating sites.										
Task Step 5…Create and educational program for staff on role-appropriate palliative care services.										
Task Step 6… Implement clinical guidelines and processes into participating sites focused to standardization of basic parameters that allows for individual partner customization based on operational/patient needs.										
Task Step 7…Quarterly reports will be provided to the clinical sub-committee for clinical reviews of the effectiveness of the standard. Adjustments will be recommended based on outcomes & team feedback. All revisions will be presented to the Clinical Integration Committee for approval.										
Milestone #2 Contract or develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the nursing home.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the nursing home.										
Task Step 1…Identify community providers and resources that provide palliative care services in nursing homes.										
Task Step 2…Consider collaboration opportunities with neighboring PPSs participating in this project.										
Task Step 3… Present recommendations for community and provider resource collaboration to the Clinical Integration and Executive Committees for approval to formalize partnerships as appropriate.										
Task Step 4… Formalize partnerships with community resources, which may include but are not limited to, provider agreement, BAA, MOUs.										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										

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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 PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form.										
Task Step 1…Identify nationally recognized clinical guidelines (i.e. Center for Advanced Palliative Care, CAPC) and PPS partner best practices to be adopted by the PPS at participating sites										
Task Step 2... Determine the number of participating providers that current utilize MOLST vs. eMOLST forms.										
Task Step 3…Project sub-committee to develop clinical guidelines for palliative care services with clinical input from participating sites.										
Task Step 4… Create an education program on the clinical guidelines for palliative care services for staff at participating sites.										
Task Step 4…Submit clinical guidelines and educational program recommendations for palliative care services to the Clinical Integration Committee and Workforce Committee for approval.										
Task Step 5… Integrate clinical guidelines into participating sites.										
Task Step 6… Quarterly reports will be provided to the clinical sub-committee for clinical reviews of the effectiveness of the standard. Adjustments will be recommended based on outcomes & team feedback. All revisions will be presented to the Clinical Integration Committee for approval.										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task Step 1…Utilize current state assessment to create a gap analysis of education and training needs of staff at participating sites.										
Task Step 2… Leverage nationally recognized training & education programs (i.e. CAPC) to train staff on palliative care services.										

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NewYork-Presbyterian/Queens (PPS ID:40)

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 Step 3…Create training/education program based on gap analysis to address the integration of palliative care services into the nursing home.										
Task Step 4… Create schedule for initial and maintenance training/education sessions.										
Task Step 5… Leverage a palliative care champion (i.e. certified/experienced MD, NP, LCSW) as a resource and on site training at participating SNFs.										
Task Step 6.. Leverage hospice lead in-service sessions at SNFs to increase knowledge of role-appropriate palliative care services and resources available.										
Task Step 7…Track staff participation in training through PMO project management software.										
Task Step 8…Quarterly reports will be provided to the clinical sub-committee for clinical reviews of the effectiveness of the standard. Adjustments will be recommended based on outcomes & team feedback. All revisions will be presented to the Clinical Integration Committee for approval.										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task Step 1…Identify uncovered palliative care services that are essential to the success of the project and improving the quality of patient care.										
Task Step 2…Present uncovered services recommendations to the Finance Committee and the Value Based Purchasing (VBP) sub-committee.										
Task Step 3…Invite MCO representatives to clinical sub-committees to educate them of the PPS project, process, and improvements.										
Task Step 4…PMO executive leadership to partner with legal teams to										

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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
outline the parameters of MCO negotiations to provide feedback to partners of next steps.										
Task Step 5…PMO to publish recommendations, compliant to Step 4 discussions, for PPS partners to approach MCO partners for negotiations of uncovered services for palliative care.										
Task Step 6…Performance Logic will be loaded with the expectation of negotiations and providers will provide monthly progress updates.										
Milestone #6 Use EHRs or other IT 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 Step 1…Communicate & discuss the definition of 'engaged patient' with the clinical sub-committee as well as the expectations for patient engagement to ensure all partners are aware of expectations.										
Task Step 2…Identify reporting capabilities by partner to track engaged patients while ensuring PHI data security. (EHR Patient Registries, Amalgam Population Health, Allscripts Care Director)										
Task Step 3…PMO to partner with any organization without the ability to track engaged patients to identify a plan of tracking.										
Task Step 4…Document process(s) by partner of tracking engaged patients.										
Task Step 5…Utilize EHRs or other platforms to track engaged patients & report to the PMO monthly regarding volume/performance.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Integrate Palliative Care into practice model of participating Nursing Homes.	
Contract or develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the nursing home.	
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	
Engage with Medicaid Managed Care to address coverage of services.	
Use EHRs or other IT platforms to track all patients engaged in this project.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	

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IPQR Module 3.g.ii.4 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 3.g.ii.5 - IA Monitoring

Instructions :

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Project 4.c.ii – Increase early access to, and retention in, HIV care

IPQR Module 4.c.ii.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.

Risk #1: The current New York State process for HIV testing is cumbersome for providers. This includes the opt-in approach for testing, provider knowledge on HIV testing, and access to care for patients.

Mitigation #1: The PPS will mitigate this risk by ensuring that all PCPs offer HIV testing, when clinically indicated, for patients and that they are well versed on the process of testing and requirements of this project.

Risk #2: Patients with behavioral health diagnoses pose an additional risk as they tend to be more complicated to manage and ensure that testing, treatment, and necessary follow-up care are received appropriately.

Mitigation #2: The HIV committee with work with the Behavioral Health committee to align strategies for engaging these pateints.

Risk #3: The existing workforce associated with collaboration, additional training and resources that will be required for participating in this domain.

Mitigation #3: PPS providers will work collaboratively with the HIV Workgroup Charter to align protocols and procedures around the integration of HIV screening and an improved linkage system, align protocols and procedures around a viral load suppression initiative, align training, protocols, and procedures around peer support programs, work together on a patient education and/or social marketing campaign, align on protocols and procedures around an EHR tool to track patients and ensure linkage to appropriate care, and design a training curriculum and/or provide joint training to PPS providers around cultural competency and HIV patients. This best practice appreciated collaboration will be addressed in the workforce organizational component so that the NYHQ PPS can contribute correspondingly to the HIV domain charter.

Risk #4: Lack of patient navigation poses a risk for this patient population.

Mitigation #4: The PPS will work with health homes to enroll patients as appropriate and will collaborate with the workforce committee to determine the need for hiring care naviagators to work with providers and patients across PPS projects.

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IPQR Module 4.c.ii.2 - PPS Defined Milestones

Instructions :

Please provide updates to baseline reporting on status, target dates, and work breakdown tasks for PPS-defined milestones.

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care.	In Progress	1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care.	08/01/2015	12/31/2016	08/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 1…Define clinical barriers to early access.	In Progress	Step 1…Define clinical barriers to early access.	08/01/2015	12/31/2015	08/01/2015	02/29/2016	03/31/2016	DY1 Q4
Task Step 2…Outline partner network & access points of care for early access & ongoing HIV care.	Completed	Step 2…Outline partner network & access points of care for early access & ongoing HIV care.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3…Utilize clinical sub-committee to communicate need & access points to partners.	Not Started	Step 3…Utilize clinical sub-committee to communicate need & access points to partners.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…Establish PPS partner agreements with partners, performance based, that incentivize clinical improvements & focus to milestones.	Completed	Step 4…Establish PPS partner agreements with partners, performance based, that incentivize clinical improvements & focus to milestones.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone 2. Increase peer-led interventions around HIV care navigation, testing, and other services.	In Progress	2. Increase peer-led interventions around HIV care navigation, testing, and other services.	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 1…Identify existing peer-led intervention strategies in coordination with other PPS	In Progress	Step 1…Identify existing peer-led intervention strategies in coordination with other PPS	09/01/2015	01/01/2016	09/01/2015	01/01/2016	03/31/2016	DY1 Q4
Task Step 2…Develop peer-role model strategy by utilizing best practices	In Progress	Step 2…Develop peer-role model strategy by utilizing best practices	09/01/2015	01/01/2016	09/01/2015	01/01/2016	03/31/2016	DY1 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 3…Present best practices to clinical subcommittee for approval	Not Started	Step 3…Present best practices to clinical subcommittee for approval	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4…Evaluate practices on a quarterly basis	Not Started	Step 4…Evaluate practices on a quarterly basis	02/01/2016	09/30/2016	02/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone 3. Launch educational campaigns to improve health literacy and patient participation in healthcare, especially among high-need populations, including: Hispanics, lesbian, gay, bisexual, and transgender (LGBT) groups.	In Progress	3. Launch educational campaigns to improve health literacy and patient participation in healthcare, especially among high-need populations, including: Hispanics, lesbian, gay, bisexual, and transgender (LGBT) groups.	11/01/2015	05/30/2017	11/01/2015	05/30/2017	06/30/2017	DY3 Q1
Task Step 1…Partner with DOH, Brightpoint Health and ACQC, CBO to create a map of high-need populations	In Progress	Step 1…Partner with DOH, Brightpoint Health and ACQC, CBO to create a map of high-need populations	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2…Utilize cross PPS work-group to develop a plan for outreach	In Progress	Step 2…Utilize cross PPS work-group to develop a plan for outreach	11/01/2015	06/01/2016	11/01/2015	06/01/2016	06/30/2016	DY2 Q1
Task Step 3. Present plan to clinical committee for approval	Not Started	Step 3. Present plan to clinical committee for approval	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4.. Launch outreach activities	In Progress	Step 4.. Launch outreach activities	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5… Evaluate on a quarterly basis	In Progress	Step 5… Evaluate on a quarterly basis	10/01/2016	05/30/2017	10/01/2016	05/30/2017	06/30/2017	DY3 Q1
Milestone 4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health.	Not Started	4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health.	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 1…Work with QCCP Health Home and DOH to identify the two most prevalent factors in the PPS catchment area	Not Started	Step 1…Work with QCCP Health Home and DOH to identify the two most prevalent factors in the PPS catchment area	01/01/2016	07/31/2016	01/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task Step 2…Evaluate best practices	In Progress	Step 2…Evaluate best practices	08/01/2016	11/30/2016	08/01/2016	11/30/2016	12/31/2016	DY2 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Step 3. Present plan to clinical committee for approval	Not Started	Step 3. Present plan to clinical committee for approval	12/01/2016	01/31/2017	12/01/2016	01/31/2017	03/31/2017	DY2 Q4
Task Step 4.. Launch outreach activities	Not Started	Step 4.. Launch outreach activities	02/01/2017	12/31/2017	02/01/2017	12/31/2017	12/31/2017	DY3 Q3
Task Step 5… Evaluate on a quarterly basis	Not Started	Step 5… Evaluate on a quarterly basis	02/01/2017	12/31/2017	02/01/2017	12/31/2017	12/31/2017	DY3 Q3
Milestone 5. Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.	In Progress	5. Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 1…Complete partner IT survey	Completed	Step 1…Complete partner IT survey	07/01/2015	11/30/2015	07/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task Step 2…Deploy IT resource to provider sites to evaluate HER and RHIO connectivity	In Progress	Step 2…Deploy IT resource to provider sites to evaluate HER and RHIO connectivity	12/01/2015	12/31/2016	12/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone 6. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care.	In Progress	6. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care.	09/01/2015	09/30/2018	09/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1…Partner with DOH, Brightpoint Health and ACQC, CBO to create a map of high prevalence areas	In Progress	Step 1…Partner with DOH, Brightpoint Health and ACQC, CBO to create a map of high prevalence areas	09/01/2015	02/01/2016	09/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 2…Utilize cross PPS work-group to develop a plan for outreach	In Progress	Step 2…Utilize cross PPS work-group to develop a plan for outreach	09/01/2015	02/01/2016	09/01/2015	02/01/2016	03/31/2016	DY1 Q4
Task Step 3. Present plan to clinical committee for approval	Not Started	Step 3. Present plan to clinical committee for approval	03/01/2016	05/30/2016	03/01/2016	05/30/2016	06/30/2016	DY2 Q1
Task Step 4.. Launch outreach activities	Not Started	Step 4.. Launch outreach activities	06/01/2016	06/01/2017	06/01/2016	06/01/2017	06/30/2017	DY3 Q1
Task Step 5… Evaluate on a quarterly basis	Not Started	Step 5… Evaluate on a quarterly basis	06/01/2016	09/30/2018	06/01/2016	09/30/2018	09/30/2018	DY4 Q2
Milestone 7. Promote delivery of HIV/STD Partner	In Progress	8. Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.	11/01/2015	12/31/2018	11/01/2015	12/31/2018	12/31/2018	DY4 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Services to at risk individuals and their partners.								
Task Step 1…Utilize cross PPS work-group to develop a plan for outreach	In Progress	Step 1…Utilize cross PPS work-group to develop a plan for outreach	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2. Present plan to clinical committee for approval	Not Started	Step 2. Present plan to clinical committee for approval	09/01/2016	10/01/2016	09/01/2016	10/01/2016	12/31/2016	DY2 Q3
Task Step 3.. Launch outreach activities	Not Started	Step 3.. Launch outreach activities	10/01/2016	12/31/2017	10/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task Step 4… Evaluate on a quarterly basis	Not Started	Step 4… Evaluate on a quarterly basis	10/01/2016	12/31/2018	10/01/2016	12/31/2018	12/31/2018	DY4 Q3

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Decrease HIV and STD morbidity and disparities; increase early access to and retention in HIV care.	Task 1 end date changed to 2/29/16 to align with HIV collaborative progress and HIV committee meeting schedule
2. Increase peer-led interventions around HIV care navigation, testing, and other services.	
3. Launch educational campaigns to improve health literacy and patient participation in healthcare, especially among high-need populations, including: Hispanics, lesbian, gay, bisexual, and transgender (LGBT) groups.	
4. Design all HIV interventions to address at least two co-factors that drive the virus, such as homelessness, substance use, history of incarceration, and mental health.	
5. Ensure that EHR systems used by participating safety net providers must meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year (DY) 3.	

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
6. Empower people living with HIV/AIDS to help themselves and others around issues related to prevention and care.	
7. Promote delivery of HIV/STD Partner Services to at risk individuals and their partners.	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 4.c.ii.3 - IA Monitoring

Instructions :

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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 'NewYork-Presbyterian/Queens', that all information provided on this Quarterly report is true and accurate to the best of my knowledge, and that, following initial submission in the current quarterly reporting period as defined by NY DOH, changes made to this report were pursuant only to documented instructions or documented approval of changes from DOH or DSRIP Independent Assessor.**

Primary Lead PPS Provider:	NEW YORK PRESBYTERIAN QUEENS
Secondary Lead PPS Provider:	
Lead Representative:	Kevin J Ward
Submission Date:	03/16/2016 04:49 PM

Comments:

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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	Kevin J Ward	mrurak	03/31/2016 05:16 PM
DY1, Q3	Submitted	Kevin J Ward	kw614719	03/16/2016 04:49 PM
DY1, Q3	Returned	Kevin J Ward	mrurak	03/01/2016 05:15 PM
DY1, Q3	Submitted	Kevin J Ward	kw614719	02/03/2016 01:48 PM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1Q3 Quarterly Report.	mrurak	03/31/2016 05:16 PM
Returned	The IA is returning the DY1Q3 Quarterly Report to the PPS for Remediation.	mrurak	03/01/2016 05:15 PM

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Section	Module Name	Status
Section 01	IPQR Module 1.1 - PPS Budget Report (Baseline)	Completed
	IPQR Module 1.2 - PPS Budget Report (Quarterly)	Completed
	IPQR Module 1.3 - PPS Flow of Funds (Baseline)	Completed
	IPQR Module 1.4 - PPS Flow of Funds (Quarterly)	Completed
	IPQR Module 1.5 - Prescribed Milestones	Completed
	IPQR Module 1.6 - PPS Defined Milestones	Completed
	IPQR Module 1.7 - IA Monitoring	
Section 02	IPQR Module 2.1 - Prescribed Milestones	Completed
	IPQR Module 2.2 - PPS Defined Milestones	Completed
	IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 2.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 2.5 - Roles and Responsibilities	Completed
	IPQR Module 2.6 - Key Stakeholders	Completed
	IPQR Module 2.7 - IT Expectations	Completed
	IPQR Module 2.8 - Progress Reporting	Completed
	IPQR Module 2.9 - IA Monitoring	
Section 03	IPQR Module 3.1 - Prescribed Milestones	Completed
	IPQR Module 3.2 - PPS Defined Milestones	Completed
	IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 3.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 3.5 - Roles and Responsibilities	Completed
	IPQR Module 3.6 - Key Stakeholders	Completed
	IPQR Module 3.7 - IT Expectations	Completed
	IPQR Module 3.8 - Progress Reporting	Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	Completed
	IPQR Module 4.2 - PPS Defined Milestones	Completed

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Section	Module Name	Status
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 4.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 4.5 - Roles and Responsibilities	Completed
	IPQR Module 4.6 - Key Stakeholders	Completed
	IPQR Module 4.7 - IT Expectations	Completed
	IPQR Module 4.8 - Progress Reporting	Completed
	IPQR Module 4.9 - IA Monitoring	
Section 05	IPQR Module 5.1 - Prescribed Milestones	Completed
	IPQR Module 5.2 - PPS Defined Milestones	Completed
	IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 5.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 5.5 - Roles and Responsibilities	Completed
	IPQR Module 5.6 - Key Stakeholders	Completed
	IPQR Module 5.7 - Progress Reporting	Completed
	IPQR Module 5.8 - IA Monitoring	
Section 06	IPQR Module 6.1 - Prescribed Milestones	Completed
	IPQR Module 6.2 - PPS Defined Milestones	Completed
	IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 6.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 6.5 - Roles and Responsibilities	Completed
	IPQR Module 6.6 - Key Stakeholders	Completed
	IPQR Module 6.7 - IT Expectations	Completed
	IPQR Module 6.8 - Progress Reporting	Completed
	IPQR Module 6.9 - IA Monitoring	
Section 07	IPQR Module 7.1 - Prescribed Milestones	Completed
	IPQR Module 7.2 - PPS Defined Milestones	Completed
	IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 7.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 7.5 - Roles and Responsibilities	Completed

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Section	Module Name	Status
	IPQR Module 7.6 - Key Stakeholders	Completed
	IPQR Module 7.7 - IT Expectations	Completed
	IPQR Module 7.8 - Progress Reporting	Completed
	IPQR Module 7.9 - IA Monitoring	
Section 08	IPQR Module 8.1 - Prescribed Milestones	Completed
	IPQR Module 8.2 - PPS Defined Milestones	Completed
	IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 8.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 8.5 - Roles and Responsibilities	Completed
	IPQR Module 8.6 - Key Stakeholders	Completed
	IPQR Module 8.7 - IT Expectations	Completed
	IPQR Module 8.8 - Progress Reporting	Completed
	IPQR Module 8.9 - IA Monitoring	
Section 09	IPQR Module 9.1 - Prescribed Milestones	Completed
	IPQR Module 9.2 - PPS Defined Milestones	Completed
	IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 9.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 9.5 - Roles and Responsibilities	Completed
	IPQR Module 9.6 - Key Stakeholders	Completed
	IPQR Module 9.7 - IT Expectations	Completed
	IPQR Module 9.8 - Progress Reporting	Completed
	IPQR Module 9.9 - IA Monitoring	
Section 10	IPQR Module 10.1 - Overall approach to implementation	Completed
	IPQR Module 10.2 - Major dependencies between work streams and coordination of projects	Completed
	IPQR Module 10.3 - Project Roles and Responsibilities	Completed
	IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects	Completed
	IPQR Module 10.5 - IT Requirements	Completed
	IPQR Module 10.6 - Performance Monitoring	Completed
	IPQR Module 10.7 - Community Engagement	Completed

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Section	Module Name	Status
	IPQR Module 10.8 - IA Monitoring	
Section 11	IPQR Module 11.1 - Workforce Strategy Spending	Completed
	IPQR Module 11.2 - Prescribed Milestones	Completed
	IPQR Module 11.3 - PPS Defined Milestones	Completed
	IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 11.5 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 11.6 - Roles and Responsibilities	Completed
	IPQR Module 11.7 - Key Stakeholders	Completed
	IPQR Module 11.8 - IT Expectations	Completed
	IPQR Module 11.9 - Progress Reporting	Completed
	IPQR Module 11.10 - Staff Impact	Completed
	IPQR Module 11.11 - IA Monitoring	

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Project ID	Module Name	Status
2.a.ii	IPQR Module 2.a.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.a.ii.2 - Patient Engagement Speed	Completed
	IPQR Module 2.a.ii.3 - Prescribed Milestones	Completed
	IPQR Module 2.a.ii.4 - PPS Defined Milestones	Completed
	IPQR Module 2.a.ii.5 - IA Monitoring	
2.b.v	IPQR Module 2.b.v.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.b.v.2 - Patient Engagement Speed	Completed
	IPQR Module 2.b.v.3 - Prescribed Milestones	Completed
	IPQR Module 2.b.v.4 - PPS Defined Milestones	Completed
	IPQR Module 2.b.v.5 - IA Monitoring	
2.b.vii	IPQR Module 2.b.vii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.b.vii.2 - Patient Engagement Speed	Completed
	IPQR Module 2.b.vii.3 - Prescribed Milestones	Completed
	IPQR Module 2.b.vii.4 - PPS Defined Milestones	Completed
	IPQR Module 2.b.vii.5 - IA Monitoring	
2.b.viii	IPQR Module 2.b.viii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.b.viii.2 - Patient Engagement Speed	Completed
	IPQR Module 2.b.viii.3 - Prescribed Milestones	Completed
	IPQR Module 2.b.viii.4 - PPS Defined Milestones	Completed
	IPQR Module 2.b.viii.5 - IA Monitoring	
3.a.i	IPQR Module 3.a.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.a.i.2 - Patient Engagement Speed	Completed
	IPQR Module 3.a.i.3 - Prescribed Milestones	Completed
	IPQR Module 3.a.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.a.i.5 - IA Monitoring	
3.b.i	IPQR Module 3.b.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.b.i.2 - Patient Engagement Speed	Completed

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Project ID	Module Name	Status
	IPQR Module 3.b.i.3 - Prescribed Milestones	Completed
	IPQR Module 3.b.i.4 - PPS Defined Milestones	Completed
	IPQR Module 3.b.i.5 - IA Monitoring	
3.d.ii	IPQR Module 3.d.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.d.ii.2 - Patient Engagement Speed	Completed
	IPQR Module 3.d.ii.3 - Prescribed Milestones	Completed
	IPQR Module 3.d.ii.4 - PPS Defined Milestones	Completed
	IPQR Module 3.d.ii.5 - IA Monitoring	
3.g.ii	IPQR Module 3.g.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.g.ii.2 - Patient Engagement Speed	Completed
	IPQR Module 3.g.ii.3 - Prescribed Milestones	Completed
	IPQR Module 3.g.ii.4 - PPS Defined Milestones	Completed
	IPQR Module 3.g.ii.5 - IA Monitoring	
4.c.ii	IPQR Module 4.c.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 4.c.ii.2 - PPS Defined Milestones	Completed
	IPQR Module 4.c.ii.3 - IA Monitoring	

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Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget Report (Baseline)	Pass & Complete	
	Module 1.2 - PPS Budget Report (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds (Baseline)	Pass & Complete	
	Module 1.4 - PPS Flow of Funds (Quarterly)	Pass & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Complete	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1 Finalize governance structure and sub-committee structure	Pass & Complete	
	Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Pass & Complete	
	Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Pass & Complete	
	Milestone #4 Establish governance structure reporting and monitoring processes	Pass & Complete	
	Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Pass & Ongoing	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass & Ongoing	
	Milestone #7 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.)	Pass & Ongoing	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Ongoing	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Complete	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Ongoing	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	
	Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	Pass & Ongoing	

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Section	Module Name / Milestone #	Review Status	
	Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	Pass & Ongoing	
	Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	Pass & Ongoing	
	Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1 Finalize cultural competency / health literacy strategy.	Pass & Complete	
	Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Pass & Ongoing	
Section 05	Module 5.1 - Prescribed Milestones		
	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).	Pass & Ongoing	
	Milestone #2 Develop an IT Change Management Strategy.	Pass & Ongoing	
	Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Pass & Ongoing	
	Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Pass & Ongoing	
	Milestone #5 Develop a data security and confidentiality plan.	Pass & Ongoing	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Pass & Ongoing	
	Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Pass & Ongoing	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1 Develop Practitioners communication and engagement plan.	Pass & Ongoing	
	Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Pass & Ongoing	
Section 08	Module 8.1 - Prescribed Milestones		
	Milestone #1 Develop population health management roadmap.	Pass & Ongoing	
	Milestone #2 Finalize PPS-wide bed reduction plan.	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		
	Milestone #1 Perform a clinical integration 'needs assessment'.	Pass & Ongoing	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Ongoing	

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Section	Module Name / Milestone #	Review Status	
Section 11	Module 11.2 - Prescribed Milestones		
	Milestone #1 Define target workforce state (in line with DSRIP program's goals).	Pass & Ongoing	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Ongoing	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Ongoing	
	Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Pass & Ongoing	
	Milestone #5 Develop training strategy.	Pass & Ongoing	

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2.a.ii	Module 2.a.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.a.ii.3 - Prescribed Milestones		
	Milestone #1 Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	Pass & Ongoing	
	Milestone #2 Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.	Pass & Ongoing	
	Milestone #3 Identify care coordinators at each primary care site who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.	Pass & Ongoing	
	Milestone #4 Ensure all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	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.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #7 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.	Pass & Ongoing	
	Milestone #8 Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.	Pass & Ongoing	
	Milestone #9 Implement open access scheduling in all primary care practices.	Pass & Ongoing	
2.b.v	Module 2.b.v.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.v.3 - Prescribed Milestones		
	Milestone #1 Partner with associated SNFs to develop a standardized protocol to assist with resolution of the identified issues.	Pass & Ongoing	
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Managed Long Term Care or FIDA Plans associated with their identified population to develop transition of care protocols, ensure covered services including DME will be readily available, and that there is a payment strategy for the transition of care services.	Pass & Ongoing	
	Milestone #3 Develop transition of care protocols that will include timely notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. Ensure that all relevant protocols allow patients in end-of-life situations to transition home with all appropriate services.	Pass & Ongoing	
	Milestone #4 Establish protocols for standardized care record transitions to the SNF staff and medical personnel.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #5 Ensure all participating hospitals and SNFs have shared EHR system capability and HIE/RHIO/SHIN-NY access for electronic transition of medical records by the end of DSRIP Year 3.	Pass & Ongoing	
	Milestone #6 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.b.vii	Module 2.b.vii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.vii.3 - Prescribed Milestones		
	Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Pass & Ongoing	
	Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Pass & Ongoing	
	Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Pass & Ongoing	
	Milestone #4 Educate all staff on care pathways and INTERACT principles.	Pass & Ongoing	
	Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Pass & Ongoing	
	Milestone #6 Create coaching program to facilitate and support implementation.	Pass & Ongoing	
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Pass & Ongoing	
	Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Pass & Ongoing	
	Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Pass & Ongoing	
	Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.b.viii	Module 2.b.viii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.viii.3 - Prescribed Milestones		
	Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Pass & Ongoing	
	Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	Pass & Ongoing	
	Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Pass & Ongoing	
	Milestone #4 Educate all staff on care pathways and INTERACT-like principles.	Pass & Ongoing	
	Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Pass & Ongoing	
	Milestone #6 Create coaching program to facilitate and support implementation.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Pass & Ongoing	
	Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	Pass & Ongoing	
	Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	Pass & Ongoing	
	Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	Pass & Ongoing	
	Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Pass & Ongoing	
	Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Pass & Ongoing	
	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.b.i.3 - Prescribed Milestones		
	Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Pass & Ongoing	
	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.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing	
3.d.ii	Module 3.d.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.d.ii.3 - Prescribed Milestones		
	Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Pass & Ongoing	
	Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Pass & Ongoing	
	Milestone #3 Develop and implement evidence-based asthma management guidelines.	Pass & Ongoing	
	Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Pass & Ongoing	
	Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Pass & Ongoing	
	Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Pass & Ongoing	
	Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.g.ii	Module 3.g.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.g.ii.3 - Prescribed Milestones		
	Milestone #1 Integrate Palliative Care into practice model of participating Nursing Homes.	Pass & Ongoing	
	Milestone #2 Contract or develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the nursing home.	Pass & Ongoing	
	Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Pass & Ongoing	
	Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Pass & Ongoing	
	Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Pass & Ongoing	
	Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
4.c.ii	Module 4.c.ii.2 - PPS Defined Milestones	Pass & Ongoing	