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

Samaritan Medical Center (PPS ID:45)

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NYS Confidentiality – High
Quarterly Report - Implementation Plan for Samaritan Medical Center

Year and Quarter: DY1, Q1  Application Status: 📦 Submitted

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<td>Section 02</td>
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<tr>
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<td>Population Health Management</td>
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<td>Section 09</td>
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<td>General Project Reporting</td>
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### Status By Project

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<th>Project Title</th>
<th>Status</th>
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<tbody>
<tr>
<td>2.a.i</td>
<td>Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management</td>
<td>✔ Completed</td>
</tr>
<tr>
<td>2.a.ii</td>
<td>Increase certification of primary care practitioners with PCMH certification and/or Advanced Primary Care Models (as developed under the NYS Health Innovation Plan (SHIP))</td>
<td>✔ Completed</td>
</tr>
<tr>
<td>2.a.iv</td>
<td>Create a medical village using existing hospital infrastructure</td>
<td>✔ Completed</td>
</tr>
<tr>
<td>2.b.iv</td>
<td>Care transitions intervention model to reduce 30 day readmissions for chronic health conditions</td>
<td>✔ Completed</td>
</tr>
<tr>
<td>2.d.i</td>
<td>Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care</td>
<td>✔ Completed</td>
</tr>
<tr>
<td>3.a.i</td>
<td>Integration of primary care and behavioral health services</td>
<td>✔ Completed</td>
</tr>
<tr>
<td>3.b.i</td>
<td>Evidence-based strategies for disease management in high risk/affected populations (adult only)</td>
<td>✔ Completed</td>
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<tr>
<td>3.c.i</td>
<td>Evidence-based strategies for disease management in high risk/affected populations (adults only)</td>
<td>✔ Completed</td>
</tr>
<tr>
<td>3.c.ii</td>
<td>Implementation of evidence-based strategies to address chronic disease - primary and secondary prevention projects (adults only)</td>
<td>✔ Completed</td>
</tr>
<tr>
<td>4.a.iii</td>
<td>Strengthen Mental Health and Substance Abuse Infrastructure across Systems</td>
<td>✔ Completed</td>
</tr>
<tr>
<td>4.b.ii</td>
<td>Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)</td>
<td>✔ Completed</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
Section 01 – Budget

**✓ IPQR Module 1.1 - PPS Budget Report**

Instructions:

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

<table>
<thead>
<tr>
<th>Budget Items</th>
<th>DY1 ($)</th>
<th>DY2 ($)</th>
<th>DY3 ($)</th>
<th>DY4 ($)</th>
<th>DY5 ($)</th>
<th>Total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Revenue</td>
<td>11,689,449</td>
<td>12,457,110</td>
<td>20,144,711</td>
<td>17,838,065</td>
<td>11,689,449</td>
<td>73,818,784</td>
</tr>
<tr>
<td>Cost of Project Implementation &amp; Administration</td>
<td>1,461,612</td>
<td>5,310,771</td>
<td>4,860,771</td>
<td>3,460,771</td>
<td>3,360,771</td>
<td>18,454,696</td>
</tr>
<tr>
<td>Revenue Loss</td>
<td>0</td>
<td>2,214,563</td>
<td>4,429,127</td>
<td>2,315,548</td>
<td>1,107,282</td>
<td>10,665,520</td>
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<tr>
<td>Cost of non-covered services</td>
<td>701,574</td>
<td>1,670,667</td>
<td>2,591,925</td>
<td>2,315,548</td>
<td>1,578,541</td>
<td>8,858,255</td>
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<tr>
<td>Other</td>
<td>756,642</td>
<td>1,624,013</td>
<td>3,764,758</td>
<td>5,546,152</td>
<td>2,602,112</td>
<td>14,293,677</td>
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<tr>
<td>Total Expenditures</td>
<td>5,258,407</td>
<td>14,251,111</td>
<td>21,687,910</td>
<td>19,880,135</td>
<td>12,741,219</td>
<td>73,818,782</td>
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<tr>
<td>Undistributed Revenue</td>
<td>6,431,042</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>45_MDL0105_1_1_20150807190505_150807 NCI Budget Implementation Plan Draft Estimates - Samaritan Lead.xlsx</td>
<td>NCI PPS Draft Budget as submitted in Organizational Implementation Plan. Uploaded due to identified discrepancies in the above budget preset calculations.</td>
<td>08/07/2015 07:05 PM</td>
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</tbody>
</table>

Narrative Text:

The spreadsheet included in the MAPP file above will not function appropriately to reflect unexpended year 1 revenue expenditures across DSRIP years as was submitted in original implementation plan per guidance received. How do you want this to be handled when it is reviewed and revised?
IPQR Module 1.2 - PPS Flow of Funds

Instructions:

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

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

<table>
<thead>
<tr>
<th>Funds Flow Items</th>
<th>DY1 ($)</th>
<th>DY2 ($)</th>
<th>DY3 ($)</th>
<th>DY4 ($)</th>
<th>DY5 ($)</th>
<th>Total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Revenue</td>
<td>11,689,449</td>
<td>12,457,110</td>
<td>20,144,711</td>
<td>17,838,065</td>
<td>11,689,449</td>
<td>73,818,784</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>368,088</td>
<td>997,578</td>
<td>1,518,154</td>
<td>1,391,609</td>
<td>891,885</td>
<td>5,167,314</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>105,168</td>
<td>285,022</td>
<td>433,758</td>
<td>397,603</td>
<td>254,824</td>
<td>1,476,375</td>
</tr>
<tr>
<td>Hospitals</td>
<td>1,472,354</td>
<td>3,990,311</td>
<td>6,072,615</td>
<td>5,566,438</td>
<td>3,567,542</td>
<td>20,669,260</td>
</tr>
<tr>
<td>Clinics</td>
<td>262,920</td>
<td>712,556</td>
<td>1,084,396</td>
<td>994,007</td>
<td>637,061</td>
<td>3,690,940</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>52,584</td>
<td>142,511</td>
<td>216,879</td>
<td>198,801</td>
<td>127,412</td>
<td>738,187</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>420,673</td>
<td>1,140,089</td>
<td>1,735,033</td>
<td>1,590,411</td>
<td>1,019,298</td>
<td>5,905,504</td>
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<tr>
<td>Substance Abuse</td>
<td>157,752</td>
<td>427,533</td>
<td>650,637</td>
<td>596,404</td>
<td>382,237</td>
<td>2,214,563</td>
</tr>
<tr>
<td>Skilled Nursing Facilities / Nursing Homes</td>
<td>262,920</td>
<td>712,556</td>
<td>1,084,396</td>
<td>994,007</td>
<td>637,061</td>
<td>3,690,940</td>
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<tr>
<td>Pharmacies</td>
<td>52,584</td>
<td>142,511</td>
<td>216,879</td>
<td>198,801</td>
<td>127,412</td>
<td>738,187</td>
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<td>Hospice</td>
<td>52,584</td>
<td>142,511</td>
<td>216,879</td>
<td>198,801</td>
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<td>738,187</td>
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<tr>
<td>Community Based Organizations</td>
<td>105,168</td>
<td>285,022</td>
<td>433,758</td>
<td>397,603</td>
<td>254,824</td>
<td>1,476,375</td>
</tr>
<tr>
<td>All Other</td>
<td>1,945,611</td>
<td>5,272,911</td>
<td>8,024,527</td>
<td>7,355,650</td>
<td>4,714,253</td>
<td>27,312,952</td>
</tr>
<tr>
<td>Total Funds Distributed</td>
<td>5,258,406</td>
<td>14,251,111</td>
<td>21,687,911</td>
<td>19,880,135</td>
<td>12,741,221</td>
<td>73,818,784</td>
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<tr>
<td>Undistributed Revenue</td>
<td>6,431,043</td>
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<td>45_MDL0106_1_1_20150924110906_150913 Funds Flow Remediation with % .xlsx</td>
<td>NCI DSRIP Funds with correct estimated undistributed revenue</td>
<td>09/24/2015 11:09 AM</td>
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</table>

Narrative Text:

Please note the undistributed tab does not calculate correctly to allow undistributed revenue to be distributed across the 5 years. The attached file provides the correct estimated undistributed revenue for each year.
spreadsheet indicates the correct undistributed revenue calculation. The funds flow has not been finalized and is part of the planning within this implementation. The table below reflects dollars in the budget but until the individual project implementation plans are undertaken and the funds flow activities above are carried out funds flow cannot be accurately placed in the categories identified. All Other is the largest category as this encompasses 1) all project implementation costs and 2) all costs for services not currently covered that the PPS intends to contract for under the NCI governance through the Safety Net lead for all partners as an integrated delivery system. The categories that are provider type specific are based on estimates of incentives, contingency, revenue loss, innovation and high performance buckets but are likely to change as the funds flow activities above are carried out and more accurate estimates are made.
### IPQR Module 1.3 - Prescribed Milestones

Instructions:

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

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
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<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td>In Progress</td>
<td>Complete funds flow budget and distribution plan and communicate with network Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>YES</td>
</tr>
<tr>
<td>Task 1.</td>
<td>In Progress</td>
<td>Develop project by project analysis of what inputs, by which providers will create the highest performing team to accomplish project deliverables and what metrics will measure and be accomplished to attest to the performance. Determine weighting to each deliverable and each provider category within the deliverable to drive funds flow</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 2.</td>
<td>In Progress</td>
<td>Distribute the project revenue impact assessment (prepared as part of current state financial stability assessment) and the project-by-project analysis to network provider partners with explanation of the purpose of the matrix and how it will 1) be used to finalize revenue loss funds flow 2) expected impact of DSRIP projects and expectations of costs incurred by the PPS and individual provider types and 3) drive incentives</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 3.</td>
<td>In Progress</td>
<td>Complete a preliminary PPS Level budget for Administration, Implementation, Revenue Loss, Cost of Services not Covered budget categories (Excludes Bonus, Contingency and High Performance categories)</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>In Progress</td>
<td>See task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
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</table>

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

Samaritan Medical Center (PPS ID:45)  

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Review the provider level projections of DSRIP impacts and costs. During provider specific budget processes, develop preliminary budgets including completion of Provider Specific funds flow plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Task 5. Develop the funds flow approach and distribution plan with drivers and requirements for each of the funds flow budget categories</td>
<td>In Progress</td>
<td>See task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 6. Distribute funds flow approach and distribution plan to Finance Committee and network participating providers for review and input</td>
<td>In Progress</td>
<td>See task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 7. Revise plan based on consultation and finalize; obtain approval from Finance Committee</td>
<td>In Progress</td>
<td>See task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 8. Prepare PPS, Provider and Project level funds flow budgets based upon final budget review sessions with network providers for review and approval by Finance Committee</td>
<td>In Progress</td>
<td>See task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 9. Communicate approved Provider Level Funds Flow plan to each network provider. Incorporate agreed upon funds flow plan and requirements to receive funds into the PPS Provider Partner Operating Agreements</td>
<td>In Progress</td>
<td>See task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 10. Distribute Funds Flow policy and procedure, and schedule DSRIP period close requirements, along with expected Funds distribution schedule, to PPS network provider partners</td>
<td>In Progress</td>
<td>See task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 11. Roll out education and training sessions for providers regarding the funds flow plan, the</td>
<td>In Progress</td>
<td>See task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
</tbody>
</table>
## Milestone/Task Name

- Administrative requirements related to the plan, and related schedules for reporting and distribution of funds. Individual sessions will be run for larger providers; collaborative group sessions will be run for smaller providers and for providers with close operational ties.

## Prescribed Milestones Current File Uploads

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
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## Prescribed Milestones Narrative Text

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<thead>
<tr>
<th>Milestone Name</th>
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<tbody>
<tr>
<td>Complete funds flow budget and distribution plan and communicate with network</td>
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</table>
### IPQR Module 1.4 - PPS Defined Milestones

Instructions:

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

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<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
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### PPS Defined Milestones Current File Uploads

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### PPS Defined Milestones Narrative Text

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<th>Milestone Name</th>
<th>Narrative Text</th>
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No Records Found
IPQR Module 1.5 - IA Monitoring

Instructions:

Funds Flow Table is not populated. PPS must populate Funds Flow Table in MAPP.
### 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.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong> Finalize governance structure and sub-committee structure</td>
<td>In Progress</td>
<td>This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Task</strong> 1. Outline the PPS governance / organizational structure</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td><strong>Task</strong> 2. Documented explanation of why selected organizational structure is critical to the success of the PPS</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td><strong>Task</strong> 3. Identify the size of the 5 primary standing committees: Payer / Finance, HIT Governance, Medical Management(clinical), Compliance, Professional Education and Workforce.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td><strong>Task</strong> 4. Select, Appoint and Install all members of the 5 standing committees: Payer / Finance, HIT Governance, Medical Management(clinical), Compliance, Professional Education and Workforce.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td><strong>Task</strong> 5. Confirm the composition and membership of the NCI Board of Managers; make adjustments to standing committees as required.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td><strong>Task</strong> 6. Develop a written process for collaborative</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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<td>Milestone/Task Name</td>
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<tr>
<td>Planning, data sharing, workforce planning, financial planning and decision making processes</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 7. Specify how the selected governance structure and processes will ensure adequate governance and management of the DSRIP program</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 8. Develop and Publish PPS Organization Chart</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 9. Written communication plan that informs PPS of organizational structure and governance</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 10. Designate / Appoint PPS compliance official (that is not /does not provide legal counsel to the PPS) Develop a PPS compliance plan that provides proper governance and oversight.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project</td>
<td>In Progress</td>
<td>This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>YES</td>
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<tr>
<td>Task 1. Draft and adopt Charter for Medical Management (Clinical Committee) for NCI</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 2. Identify membership/leadership for Project-level Clinical Quality Sub-committees for the 11 PPS projects and develop clinical committee organizational structure chart.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 3. Draft and adopt project timeline &amp; milestone template for clinical projects</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td>Task 4. Identify and adopt evidence-based protocols for each Domain 3 project and others as appropriate</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td>Task 5. Develop regular meeting schedules for Committee and relevant sub-Committees</td>
<td>In Progress</td>
<td>See Task</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 7. PPS PMO will support continuous clinical quality improvement activities for the Medical Management Committee to evaluate the standards, benchmark training performance, identify and determine best practices. Quality committees will perform routine clinical assessments against performance metrics for the 11 DSRIP Projects.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Milestone #3</td>
<td>In Progress</td>
<td>This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 1. North Country Initiative (NCI) Board of Managers will collaboratively develop and draft PPS bylaws.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 2. Collaboratively the NCI Board of Managers will review and approve developed Bylaws for the PPS.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 3. Adopt revised North Country Initiative Board of Managers Bylaws.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 4. Identify key policies regarding participation in North Country Initiative governance structure</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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NYS Confidentiality – High
## Samaritan Medical Center (PPS ID: 45)

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<tr>
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<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
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</thead>
<tbody>
<tr>
<td><strong>Task</strong> 5. Draft and adopt dispute resolution policies and procedures that will address: Issue / Conflict resolution by NCI Board of Managers.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 6. Develop, adopt, and communicate policies and procedures regarding non- or under-performing providers</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td><strong>Task</strong> 7. Develop and adopt Governance compliance policies and procedures</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td><strong>Milestone #4</strong> Establish governance structure reporting and monitoring processes</td>
<td>In Progress</td>
<td>This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Task</strong> 1. NCI Project Management Office and Project Leads will utilize PMI methodologies and Performance Logic Project Management software to actively manage project performance and produce real-time performance dashboards for controlling, monitoring and reporting purposes to the NCI Board of Managers and Key Stakeholders for approval. Dashboards will be adjusted to meet reporting criteria as determined by the NCI Board of Managers.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td><strong>Task</strong> 2. Identify key project metrics to assess project workstream progress: financial management, clinical management, workforce management, IT management and Compliance.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td><strong>Task</strong> 3. PMO will create reporting and controlling dashboard structure for milestone completion status reports.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td><strong>Task</strong> 4. Develop tools that support data collection and reporting data from participating PPS</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<td>entities.</td>
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<tr>
<td>Task 5. Utilize established tools (MAPP) and methodologies for submitting metrics, project status, and financial management to NCI Board of Managers and mandated quarterly reports as required.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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</tr>
<tr>
<td>Task 6. Communicate compliance policies and procedures to the partners and vendors of the NCI PPS, as appropriate</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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</tr>
<tr>
<td>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)</td>
<td>In Progress</td>
<td>Community engagement plan, including plans for two-way communication with stakeholders.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 1. Identify community resources and organizations participating in activities impacting population health, including food, clothing, shelter assistance</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 2. Communicate and promote those community resources who are participating in activities to improve population health (food, clothing, shelter assistance, churches etc)</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 3. Recruit participants for NCI Committee leadership and participation</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
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<td>09/30/2015</td>
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<tr>
<td>Task 4. Utilize FDRHPO Communication Committee to identify and develop communication channels for two-way community engagement and coordination with surrounding PPSs</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 5. Utilize FDRHPO population health management committee to inform community</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</table>
### Milestone/Task Name
- **Task 1.** Identify key CBOs willing to participate in DSRIP projects by entering into contractual / partnership agreements.
- **Task 2.** Develop workforce communication and engagement strategy: Vision, Objectives, Guiding Principles, and Stakeholder Engagement.
- **Task 3.** Develop workforce communication and engagement plan: Objectives, Principles, Target Audience, Channel, Barriers and Risks and Milestones.
- **Task 4.** Determine key deliverables and key performance indicators (KPIs) for inclusion in agreements with key CBOs.
- **Task 5.** Negotiate and draft contractual / partnership agreements with key CBOs.
- **Milestone #6.** Finalize partnership agreements or contracts with CBOs.
- **Task 6.** Finalize Community Engagement Plan in partnership with Population Health Management Program including plans for two way communication as part of overall NCI Communication Plan.
- **Task 7.** Define Roles and Responsibilities of our public and non provider organizations, while developing a template for referrals.

### Status
- In Progress

### Description
- outreach within the community engagement plan that will support population health engagement across all of NCI region and coordinate with surrounding PPSs.
- See Task
- See Task
- Signed CBO partnership agreements or contracts.
- See Task
- See Task
- See Task
- See Task
- See Task

### Start Date
- 04/01/2015

### End Date
- 12/31/2015

### Quarter End Date
- 12/31/2015

### DSRIP Reporting Year and Quarter
- DY1 Q3

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

**Samaritan Medical Center (PPS ID:45)**

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<tbody>
<tr>
<td><strong>Task</strong> 6.</td>
<td>In Progress</td>
<td>Finalize contractual / partnership agreements with key CBOs</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td><strong>Task</strong> 7. Identify appropriate committees for CBO representation, including Finance</td>
</tr>
<tr>
<td><strong>Milestone #7</strong></td>
<td>In Progress</td>
<td>Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td><strong>Task</strong> 1. Identify appropriate public sector agencies at the state and local level in the NCI service area</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td><strong>Task</strong> 2. Develop an action plan for coordinating supporting agency activities geographically within the PPS for discussion, review, and adoption by the Agencies and Municipal Authorities</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td><strong>Task</strong> 3. Include public sector agencies in internal and external committee structures</td>
</tr>
<tr>
<td><strong>Task</strong> 4.</td>
<td>In Progress</td>
<td>Include public sector agency coordination action plan in two-way NCI Communication Plan</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td><strong>Task</strong> 5. NCI public sector agency coordination plan discussed, reviewed and adopted</td>
</tr>
<tr>
<td><strong>Milestone #8</strong></td>
<td>In Progress</td>
<td>Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td><strong>Task</strong> 1. Identify, assess and stratify CBO's into geographical and services available categories</td>
</tr>
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</table>

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<th>Milestone/Task Name</th>
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<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 2. Establish linkages with CBO's in the PPS's geographical targeted population areas</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 3. Develop engagement plan that outlines numbers of CBO's required, service requirements and alignment of CBO’s specific roles and responsibilities in achieving DSRIP deliverables.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 4. Identify and appoint representation from CBO's on governing body and to appropriate committees.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 5. Partner with and contract CBO's in: care management, community health workers, project 11 navigation, diabetes prevention program, tobacco cessation, cultural competency and health literacy.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 6. Utilize existing CBO expertise in the prevention of over-growth or duplication existing services</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 7. Implement key deliverables and key performance indicators (KPIs) outlined in agreements with CBOs.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 8. Implement and utilize communications engagement plan to: inform, improve, sustain two-way communications. Where appropriate and accepted utilize electronic referrals processes.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 9. Conduct an assessment of the region on which CBO’s are not participating in DSRIP, if any are identified work to gain commitment to join the NCI PPS.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Milestone/Task Name</td>
<td>Status</td>
<td>Description</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
<td>AV</td>
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</tr>
<tr>
<td><strong>Milestone #9</strong> Finalize workforce communication and engagement plan</td>
<td>In Progress</td>
<td>Workforce communication &amp; engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g., workforce transformation committee).</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Task</strong> 1. Utilize FDRHPO communication and workforce committee to review and create the communication and engagement plans</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 2. Review committee members to ensure proper representation from the key areas of our PPS, (i.e. employees, unions, fqhc’s, providers, cbo’s, health homes etc.)</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 3. Communication committee to perform workforce stakeholder assessment in partnership with the workforce committee to identify the key stakeholder groups and evaluate current commitment and level of commitment required for project success</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 4. Define the communication needs and required key messages by workforce audience group, as well as the available communication channels that can be utilized for workforce stakeholder engagement</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 5. Develop two-way workforce communication and engagement plan as component of NCI overall two-way communication plan including: objectives, target audience, channel, barriers and risks, milestones, and measures to evaluate effectiveness</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 6. Workforce Communication &amp; Engagement section of NCI Communication Plan; signed off by the executive body of the PPS</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
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## Prescribed Milestones Current File Uploads

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
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<tbody>
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## Prescribed Milestones Narrative Text

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

Instructions:

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

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

PPS Defined Milestones Current File Uploads

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

PPS Defined Milestones Narrative Text

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

No Records Found
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: Due to the region's severe health provider shortages, retaining appropriate physician commitment on boards can be difficult.
Mitigation:
NCI has a broad range of specialty CBO involved in committees to represent a broad spectrum of the region's needs & resources, so not all responsibilities fall on our primary care physicians. In addition, a single clinical governance committee may have the role to serve as the clinical committee for multiple projects within their expertise.

Risk 2: With the large geographic area NCI covers physical attendance to meetings may be difficult.
Mitigation:
The use of video conferencing, teleconferencing, and webcasts has been defined and implemented by PPS.

Risk 3: Collecting participant level data from PPS partners.
Mitigation:
a.) NCI utilize a centralized platform (performance logic) to manage project planning implementation & reporting with real time data.
b.) NCI will implement population health management tools for monitoring of clinical based data & evidenced based medicine.

Risk 4: Gaining agreement on evidence based clinical guidelines by the Medical Management (Clinical) Committee & the ability to monitor participant's adherence.
Mitigation:
Medical Management Committee will select National accepted evidence based clinical practice guidelines and utilize IT capabilities.

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.)

1. Practitioner, Community and Workforce Engagement: Across the entire PPS, a community engagement plan, including plans for two-way communication with stakeholders will be developed. This plan will include communication with all levels of the governance, regarding required trainings, recruitment and retention strategies (i.e. alignment with and awareness of federal and state initiatives), and new hires. The PPS governance structure will be responsible for agency coordination plans aimed at engaging appropriate and targeted workers who will most greatly
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

impacted by project implementation. Practitioner engagement and involvement in the DSRIP program will also be a major interdependency with our workforce transformation plans. As such, we will develop training and education plans targeting practitioners and other professional groups, designed to educate them about the DSRIP Program and our PPS-specific quality improvement agenda.

2. Financial Sustainability: Key people within organizations will need to be identified and held responsible for the financial sustainability of their entities, incorporating PPS strategies to address important, identified issues related to our network's financial health. The financial sustainability of PPS partners greatly impact governance.

3. Cultural Competency and Health Literacy: The implementation of cultural competence and health literacy strategies will require the identification and implementation of assessments and tools to assist patients with self-management of conditions, as well as the utilization of community-based interventions to reduce health disparities and improve outcomes. The PPS Governance will need to adopt a culturally competent training strategy for clinicians focused on evidence-based research addressing the drivers of health disparities for particular groups identified. We will also create training plans for other segments of the workforce (and others, as appropriate) regarding specific population needs and effective patient engagement approaches.

4. IT Systems and Processes: All projects and workstreams are dependent on the IT systems and processes, therefore, strategic implementation of these systems and processes is primarily dependent on workforce related to both clinical and technical training. The PPS will develop an IT change management strategy that is focused on a communication plan involving all stakeholders, including users. An education and training plan will be created and workflows for authorizing and implementing IT changes will be defined and standardized across the PPS. This training plan will support the successful implementation of new platforms and processes involving technical standards and implementation guidance for sharing and using a common clinical data set.

5. Performance Monitoring: Each entity will be required to report clinical and financial outcomes for specific patient pathways and project milestones. Key personnel will need to be trained to use clinical quality and performance dashboards as well as a centralized, continuously monitored reporting tool. Reporting, tracking, monitoring and course adjustments will need to be made by the organization and their workers, in partnership with the PPS Project Management Officer. The Governance structure will need to be proactive and rapidly reactive with improvement plans for areas of poor performance.
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project
Samaritan Medical Center (PPS ID:45)

IPQR Module 2.5 - Roles and Responsibilities

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Applicant/Entity</td>
<td>North Country Initiative, LLC with Samaritan as signatory</td>
<td>Bylaw and Policy Development, funding and staff resources</td>
</tr>
<tr>
<td>North Country Initiative, LLC Board of Managers</td>
<td>Governance</td>
<td>Oversight and success of all DSRIP Activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Policy and Plan Adoption and Executive Sponsor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Physician and Provider Champions and Leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Overall DSRIP Performance Monitoring</td>
</tr>
<tr>
<td>DSRIP Project Advisory Committee</td>
<td>Multi-organizational</td>
<td>Review and make recommendations to the NCI Board on DSRIP strategies and Plans</td>
</tr>
<tr>
<td>NCI Medical Management (Clinical)Committee</td>
<td>Clinical Governance</td>
<td>Clinical Oversight for DSRIP Projects</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical Guideline &amp; Protocol Development and Support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical Champions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality of Care and Patient Outcomes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PHM Disease Registry Quality Measures - Performance Monitoring</td>
</tr>
<tr>
<td>NCI HIT Governance Committee</td>
<td>HIT Assessment, Plan, Adoption</td>
<td>Responsible for reviewing HIT Gap Analysis and Plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Championing adoption by clinicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient-Centered Medical Home implementation plan</td>
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<tr>
<td></td>
<td></td>
<td>EMR and MU</td>
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<tr>
<td></td>
<td></td>
<td>PHM Disease Registry roll-out</td>
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<tr>
<td>NCI Finance Committee</td>
<td>Financial Plan Monitoring Funds Flow Oversight</td>
<td>Review of Financial Sustainability Plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitoring Fragile Provider Metrics</td>
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<tr>
<td></td>
<td></td>
<td>Review of Funds Flow Plan</td>
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<tr>
<td></td>
<td></td>
<td>Inform and Review Value Based Payment Strategy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other financial and value-based planning functions</td>
</tr>
<tr>
<td>NCI Compliance Committee</td>
<td>Compliance</td>
<td>Responsible to ensure Compliance Plans, Policies and Training are in place including Lead Entity Compliance Plan consistent with New York State Social Services Law 363-d</td>
</tr>
<tr>
<td>NCI Health Literacy &amp; Cultural Competency Committee</td>
<td>Health Literacy &amp; Cultural Competency Plans</td>
<td>Development of Health Literacy and Cultural Competency Strategy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Development and oversight of Health Literacy and Cultural Competency Training Plan in partnership with Workforce Committee</td>
</tr>
<tr>
<td>NCI Provider Recruitment, GME &amp; Workforce Governance Committee</td>
<td>Workforce</td>
<td>Physician/Provider Recruitment Plan</td>
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<tr>
<td></td>
<td></td>
<td>GME Expansion Analysis</td>
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</tbody>
</table>

NYS Confidentiality – High
<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCI Care Coordination Committee</td>
<td>Care Coordination across continuum of care</td>
<td>Workforce Roadmap Adoption&lt;br&gt;Workforce Training Strategy Adoption&lt;br&gt;Care Management and Transitions to include:&lt;br&gt;Hospital Transitions&lt;br&gt;Health Home Care Management&lt;br&gt;Home Care and Hospice&lt;br&gt;Primary Care-Care Managers&lt;br&gt;Community Health Workers</td>
</tr>
<tr>
<td>Behavioral Health Committee (FDRHPO)</td>
<td>Behavioral Health Integration 2.a.i&lt;br&gt;Strengthen BH Infrastructure 4.a.iii</td>
<td>Planning and support for Behavioral Health strategies across PPS including integration of Primary Care and Behavioral Health, Strengthening Behavioral Health Infrastructure, Behavioral Health Care Transitions</td>
</tr>
<tr>
<td>North Country Health Compass Committee</td>
<td>Population Health Improvement Program bridge</td>
<td>Identifying Neighborhood and community needs&lt;br&gt;Hot Spotting&lt;br&gt;Population Health&lt;br&gt;Health Disparities&lt;br&gt;PAM navigation priority</td>
</tr>
<tr>
<td>Workforce Strategies Committee (FDRHPO)</td>
<td>Workforce Planning</td>
<td>Develop Workforce Gap Analysis&lt;br&gt;Develop Workforce Roadmap&lt;br&gt;Develop Workforce Strategy</td>
</tr>
<tr>
<td>Safety Net hospital partners</td>
<td>Samaritan Medical Center&lt;br&gt;River Hospital&lt;br&gt;Claxton-Hepburn Hospital&lt;br&gt;Clifton-Fine Hospital&lt;br&gt;Massena Memorial Hospital&lt;br&gt;Carthage Area Hospital</td>
<td>Board and Committee members, staff support</td>
</tr>
<tr>
<td>Physician Organizations, Practices and Community Based Organizations</td>
<td>Watertown Internist Lowville Medical Associates Pulmonology Associates&lt;br&gt;Howard T. Mery, MD PC&lt;br&gt;Children's Home of Jefferson County&lt;br&gt;North Country Family Health Center&lt;br&gt;Each County Community Services Board Northern Regional Center for Independent Living&lt;br&gt;Mental Health Association, and many other CBOs on Advisory Board and sub-committees</td>
<td>Board and Committee members, EBM protocols</td>
</tr>
<tr>
<td>Health Homes</td>
<td>Case &amp; Care management protocol &amp; procedures&lt;br&gt;Central New York Health Home Network &amp; subcontracted partners</td>
<td>Board and Committee members, EBM protocols</td>
</tr>
<tr>
<td>Major CBOs and/or social service agencies</td>
<td>As identified throughout the DSRIP projects</td>
<td>Board and Committee members, program information, liaisons</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key advisors, counselors, attorneys, consultants</td>
<td>Iseman, Cunningham, Riester and Hynde, LLP</td>
<td>Drafts governance documents, provider agreements, policies and procedures, etc.</td>
</tr>
</tbody>
</table>
### Module 2.6 - IPQR Module 2.6 - Key Stakeholders

Instructions:

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

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Applicant/Entity</td>
<td>North Country Initiative, LLC with Samaritan as signatory</td>
<td>Bylaw and Policy Development, funding and staff resources</td>
</tr>
<tr>
<td>Major hospital partners</td>
<td>Samaritan Medical Center, River Hospital, Claxton-Hepburn Hospital, Clifton-Fine Hospital, Massena Memorial Hospital,</td>
<td>Board and Committee members, staff support</td>
</tr>
<tr>
<td></td>
<td>Carthage Area Hospital</td>
<td></td>
</tr>
<tr>
<td>All PPS Partners</td>
<td>All PPS Partners</td>
<td>Active role in governance, communication, and project activities and deliverables</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Fort Drum Regional Health Planning Organization | Workforce Vendor Assistance IT infrastructure  
Contracted PMO staffing and Support Coordination of Activities | Training and Education IT Partnership Facilitation of Activities Continuity & Credibility            |
| North Country Behavioral Healthcare Network | Project 4.a.iii and 3.a.i. support and assistance                                                                   | PAC Participation, Project leadership                                                               |
| Non-Partner Community Based Organizations  | Engagement                                                                                                           | Understanding and buy-in                                                                              |
| Medicaid and Uninsured Patients, All Population for Population Health Projects | Participation in neighborhood and community engagement activities, potential community health worker roles of the future | Information to ensure projects and activities are effective and appropriately targeted                 |
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.

North Country Initiatives, ability to obtain information quickly on a patient’s health, health care, and potential treatments is critically important. Additionally, the ability to share this information in a timely manner with other providers caring for the patient is essential to the delivery of safe, patient-centered, coordinated, and efficient health care. To meet this need, collaboration across the entire PPS is underway to develop and leverage: electronic health record (EHR) systems with decision support for clinicians, a secure platform for the exchange of patient information across health care settings, and data standards that will make shared information understandable to all users. Efforts are also underway to complete the implementation of a population health management tool that will allow our PPS to analyze, and aggregate real time data on our participants and those beneficiaries who opt in. NCI through the use of this tool will also be able to leverage information systems for mental health and substance abuse providers. Ensuring that the developing systems for mental health and substance abuse conditions are aligned with general, medical care needs is essential for improving the quality and continuity of care across the system. NCI's PPS will not be successful within DSRIP or any other Healthcare reform initiative if our information technology cannot produce reports on our ability to deliver safe, effective, patient-centered, timely health care. Those reports will be allow our PPS to take data and turn that information into healthcare decisions which will allow for improved patient outcomes and a reduction in healthcare cost.

All staff and participating providers will need to be trained on protecting health information through appropriate privacy and security practices. They will need to be trained on effective strategies to achieve ongoing, industrywide Health IT standards to include information tools, specialized network functions, and security protections for the interoperable exchange of health information. They will need to learn how to identify health IT standards for use by identifying and prioritizing specific uses for which health IT is valuable, beneficial and feasible. Overall, strong commitment from PPS to train, understand, and embrace the development of a shared, secure IT infrastructure will ultimately impact the successful use of IT functionality to improve outcomes.

It is vital to recognize the importance that our IT infrastructure has on our regions ability to reverse the cost curve and to improve the outcome of all the patients this region serves. Improvement in Information technology has been a commitment this region has made and will maintain throughout the regions transformation.

IPQR Module 2.8 - Progress Reporting

Instructions:

Please describe how you will measure the success of this organizational workstream.
The success of North Country Initiative governance will be measured against the timely achievement of the creation of the structures (Board of Directors, Committees Organizational chart), the recruitment of Board of Directors and committee members, the development and adoption of bylaws, policies and procedures for all key committees and sub-committees, and the development, negotiation and execution of all required provider agreements to allow NCI to begin operating as a PPS. Additionally, success will be measured by the establishment of the population health management tool and performance management systems (including data collection, analyses and reporting) to support effective and efficient decision-making. Our PPS will rely heavily on the IT infrastructure and tools that will help assist in project management and clinical reviews. Our project management officer and those PPS identified members will utilize a software program to help manage the 11 DSRIP projects, and financial obligations. Our clinical committees including but not limited to medical management, HIT, Care transitions committee will rely on the population health management software to capture data regarding the clinical measures, compliance with EBM (evidence-based medicine) protocol, and ultimately with the impact on the project goals and the overall NYS goal of reduction in avoidable hospital admissions.

North Country Initiative (NCI) has established a Project Management Office (PMO) staffed with a certified Project Management Officer and Program Manager. The PMO will utilize, Performance Logic, a project management performance based software platform for monitoring, controlling and reporting (weekly, monthly, quarterly) status / metrics associated with project milestones / deliverables. Performance Logic is specifically designed to the needs of the PPS with project management, implementation, planning, performance monitoring and results oriented project tracking / reporting. Performance Logic incorporates all aspects of DSRIP tracking enhancing NCI's ability to communicate with multiple team members and essential stakeholders.

**IPQR Module 2.9 - IA Monitoring**

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

**IPQR Module 3.1 - Prescribed Milestones**

Instructions:

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

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<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
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<td><strong>Milestone #1</strong></td>
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<tr>
<td>Finalize PPS finance structure, including reporting structure</td>
<td>In Progress</td>
<td>This milestone must be completed by 12/31/2015. PPS finance structure chart/document, signed off by PPS Board.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>YES</td>
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<tr>
<td>Task 1. With assistance from PPS CFO establish the financial structure with oversight for DSRIP within the Governance organization and the role and responsibilities of the DSRIP Finance Committee and Compliance Committee and related functions</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td><strong>Task</strong> 2. Define the Roles and Responsibilities of the PPS Lead and Finance function</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td><strong>Task</strong> 3. Develop charter for the PPS finance function and establish schedule for DSRIP Finance Committee meetings.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td><strong>Task</strong> 4. Develop PPS Org chart that depicts the complete DSRIP finance function with reporting structure to Executive Body and oversight committees</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td><strong>Task</strong> 5. Obtain PPS Executive Body approval of PPS Finance Function charter and organization structure chart</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<td><strong>Milestone #2</strong></td>
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<tr>
<td>This milestone must be completed by 3/31/2016. Network financial health</td>
<td>In Progress</td>
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<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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## Samaritan Medical Center (PPS ID: 45)

<table>
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<tr>
<th>Milestone/Task Name</th>
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<th>Start Date</th>
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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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</table>
| Perform network financial health current state assessment and develop financial sustainability strategy to address key issues. | In Progress  | - 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 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 | 04/01/2015  | 09/30/2015 | 09/30/2015        | DY1 Q2                           |    |
<p>| Task 1. Develop matrix of DSRIP Projects and identify expected impact on provider cost, patient volumes, revenue, LOS or other based upon project goals and participation | In Progress  | Milestone: Assessment of DSRIP Project Impacts                                                                                                         | 04/01/2015  | 09/30/2015 | 09/30/2015        | DY1 Q2                           |    |
| Task 2. Review DRAFT of Project Impact matrix with Finance Committee                 | In Progress  | Milestone: Assessment of DSRIP Project Impacts                                                                                                         | 04/01/2015  | 09/30/2015 | 09/30/2015        | DY1 Q2                           |    |
| Task 4. Develop schedules and timelines to monitor the financial status of the PPS partners, with specific attention to the financially fragile watch list | In Progress  | Milestone: Assessment of DSRIP Project Impacts                                                                                                         | 04/01/2015  | 12/31/2015 | 12/31/2015        | DY1 Q3                           |    |
| Task 5. Review and obtain approval of Project Impact Matrix from Finance Committee and Executive Body as basis for Sustainability and applicable portions of funds flow plan | In Progress  | Milestone: Assessment of DSRIP Project Impacts                                                                                                         | 04/01/2015  | 12/31/2015 | 12/31/2015        | DY1 Q3                           |    |
| Task 6. Ensure collaboration and partnership in conjunction with the VAPAP process and milestones | In Progress  | Milestone: Assessment of DSRIP Project Impacts                                                                                                         | 04/01/2015  | 12/31/2015 | 12/31/2015        | DY1 Q3                           |    |
| Task 7. Define essential safety net provider partners with volume and responsibilities that | In Progress  | Milestone: Conduct Current State Financial Assessment and Project Impact Assessment                                                                   | 04/01/2015  | 09/30/2015 | 09/30/2015        | DY1 Q2                           |    |</p>
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<tr>
<th>Milestone/Task Name</th>
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<td>significantly impact DSRIP Program Outcomes</td>
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<tr>
<td><strong>Task 11.</strong> Prepare report of PPS Current State Financial Status for Executive Body</td>
<td>In Progress</td>
<td>Milestone: Conduct Current State Financial Assessment and Project Impact Assessment</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task 12.</strong> Define procedure for ongoing monitoring of financial stability and obtain approval from Executive Body.</td>
<td>In Progress</td>
<td>Milestone: Conduct Current State Financial Assessment and Project Impact Assessment</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task 13.</strong> Based upon Financial Assessment and Project Impact Assessment – identify providers (a) not meeting Financial Stability Plan metrics, (b) that are under current or planned restructuring efforts, or that will be financially challenged due to DSRIP projects or (c) that will otherwise be financially challenged and, with consideration of their role in projects, prepare initial Financially Fragile Watch List and obtain approval of Finance Committee.</td>
<td>In Progress</td>
<td>Milestone: Develop Financially Fragile Watch List</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task 14.</strong> In partnership with KPMG and VAPAP Teams develop PPS Financial fragile watch list, and essential entity list to ensure partners in the PPS are financially sustainable and able to</td>
<td>In Progress</td>
<td>Milestone: Develop Financially Fragile Watch List</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
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<td>meet the needs of DSRIP.</td>
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<tr>
<td>Task 15. In partnership with KPMG and VAPAP Teams develop PPS Financial Stability plan. The plan will include metrics, ongoing monitoring process, and other requirements.</td>
<td>In Progress</td>
<td>Milestone: Develop Financial Stability Plans and Distressed Provider Plans and obtain approval from PPS Finance Committee &amp; Executive Body</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td>Task 16. Define role of PPS and VAPAP process for evaluating metrics and implementing a FSP for the initial Fragile Watch List as well as going forward.</td>
<td>In Progress</td>
<td>Milestone: Develop Financial Stability Plans and Distressed Provider Plans and obtain approval from PPS Finance Committee &amp; Executive Body</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
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<tr>
<td>Task 17. Define template for Distressed Provider Plan(s)</td>
<td>In Progress</td>
<td>Milestone: Develop Financial Stability Plans and Distressed Provider Plans and obtain approval from PPS Finance Committee &amp; Executive Body</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
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<tr>
<td>Task 18. Define process for evaluating metrics and implementing a DPP for Financially Fragile providers in partnership with KPMG/DOH VAPAP plans</td>
<td>In Progress</td>
<td>Milestone: Develop Financial Stability Plans and Distressed Provider Plans and obtain approval from PPS Finance Committee &amp; Executive Body</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
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<tr>
<td>Task 20. Obtain approval of Finance Committee</td>
<td>In Progress</td>
<td>Milestone: Develop Financial Stability Plans and Distressed Provider Plans and obtain approval from PPS Finance Committee &amp; Executive Body</td>
<td>04/01/2015</td>
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<tr>
<td>Task 21. Obtain approval of Executive Body</td>
<td>In Progress</td>
<td>Milestone: Develop Financial Stability Plans and Distressed Provider Plans and obtain approval from PPS Finance Committee &amp; Executive Body</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d</td>
<td>In Progress</td>
<td>This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>YES</td>
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<tr>
<td>Task 1. Complete review of NY Social Services Law 363-d, determine scope and requirements of compliance program and plan based upon the DSRIP related requirements that are within the scope of responsibilities of the PPS Lead.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
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<td>DY1 Q2</td>
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<td><strong>Task</strong> 2. Develop written policies and procedures to be reviewed and created with the guidance of the PPS CFO AND CCO. Those policies and procedures will define and implement the code of conduct and other required elements of the PPS Lead compliance plan that are within the scope of responsibilities of the PPS Lead.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td><strong>Task</strong> 3. Obtain confirmation from PPS network providers that they have implemented a compliance plan consistent with the NY State Social Services Law 363-d.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td><strong>Task</strong> 4. Develop requirements to be included in the PPS Provider Operating Agreement that the network providers will maintain a current compliance plan to meet NY State requirements for a provider.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
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<tr>
<td><strong>Task</strong> 5. Obtain Executive Body approval of the Compliance Plan (for the PPS Lead) and Implement</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
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<tr>
<td><strong>Milestone #4</strong> Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.</td>
<td>In Progress</td>
<td>This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Task</strong> 1. Develop VBP Work Group representative of PPS system with representation from PPS providers, PCMH, FQHCs and plans. (NOTE: Finance Committee may fulfill this function)</td>
<td>In Progress</td>
<td>Milestone: Establish Value Based Payment Work Group</td>
<td>04/01/2015</td>
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<tr>
<td><strong>Task</strong> 2. Develop VBP Work Group Charter. The NCI VBP Work Group will hold responsibility for facilitating the achievement of the Value-Based</td>
<td>In Progress</td>
<td>Milestone: Establish Value Based Payment Work Group</td>
<td>04/01/2015</td>
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<tr>
<td>Task 3. VBP workgroup to create additional details and engagement plan on how PPS will involve key stakeholders and physicians</td>
<td>In Progress</td>
<td>Milestone: Establish Value Based Payment Work Group</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
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<tr>
<td>Task 4. Create VBP workplan to include steps towards negotiation and contract execution, and physician readiness</td>
<td>In Progress</td>
<td>Milestone: Establish Value Based Payment Work Group</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
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<tr>
<td>Task 5. Develop education and communication plan for providers integrated with the Workforce Roadmap and the NCI Communication Plan to facilitate understanding of value based payment (VBP), to include levels of VBP, risk sharing, and provider/MCO contracting options.</td>
<td>In Progress</td>
<td>Milestone: Develop education and communication strategy for PPS network.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td>Task 6. Develop educational materials to be used during provider outreach and educational campaign.</td>
<td>In Progress</td>
<td>Milestone: Develop education and communication strategy for PPS network.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 7. Conduct education and outreach campaign for PPS system providers to broaden knowledge among the PPS network of the various VBP models and to enable the PPS to employ those models in a coordinated approach (campaign to include in-person and web-based educational sessions for providers).</td>
<td>In Progress</td>
<td>Milestone: Conduct Stakeholder Engagement with PPS Providers</td>
<td>04/01/2015</td>
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<td>Task 8. Develop a stakeholder engagement survey to assess the PPS provider population and establish a baseline assessment of (at least) the following: Degree of experience operating in VBP models and preferred compensation modalities; Degree of sophistication in ability to negotiate plan contracts, monitor and report on service types; Estimated volume of Medicaid</td>
<td>In Progress</td>
<td>Milestone: Conduct Stakeholder Engagement with PPS Providers</td>
<td>04/01/2015</td>
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<td>Managed Care spending received by the network. Estimate of total cost of care for specific services (modeled along bundles Status of requisite IT linkages for network funds flow monitoring. Provider ability (financial stability) and willingness to take downside risk in a risk sharing arrangement. Preferred method of negotiating plan options with Medicaid Managed Care organization (e.g. as a single provider, as a group of providers, through the PPS) Level of assistance needed to negotiate plan options with Medicaid Managed Care (High, Moderate, Low).</td>
<td>In Progress</td>
<td>Milestone: Conduct Stakeholder Engagement with PPS Providers</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
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<td>DY1 Q3</td>
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<tr>
<td>Task 9. Roll out stakeholder engagement survey to the provider population to determine PPS baseline demographics.</td>
<td>In Progress</td>
<td>Milestone: Conduct Stakeholder Engagement with PPS Providers</td>
<td>04/01/2015</td>
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<tr>
<td>Task 10. Conduct provider outreach sessions to supplement the stakeholder engagement survey and engage stakeholders in open discussion.</td>
<td>In Progress</td>
<td>Milestone: Conduct Stakeholder Engagement with PPS Providers</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
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<tr>
<td>Task 11. Compile stakeholder engagement survey results and findings from provider engagement sessions and analyze findings.</td>
<td>In Progress</td>
<td>Milestone: Conduct Stakeholder Engagement with PPS Providers</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
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<tr>
<td>Task 12. Conduct stakeholder engagement sessions with MCOs to understand potential contracting options and the requirements (workforce, infrastructure, knowledge, legal support, etc.) necessary</td>
<td>In Progress</td>
<td>Milestone: Conduct stakeholder engagement with MCOs</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
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<tr>
<td>Task 13. Develop initial PPS VBP Baseline Assessment, based on feedback from provider and MCO stakeholder engagement sessions and survey results, providing an overview of the</td>
<td>In Progress</td>
<td>Milestone: Finalize PPS VBP Baseline Assessment</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
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## Milestone/Task Name

### Task 14. Circulate the NCI PPS VBP Baseline Assessment for open comment among network providers to help ensure accuracy and understanding.

- **In Progress**
- **Milestone:** Finalize PPS VBP Baseline Assessment
- **Start Date:** 04/01/2015
- **End Date:** 03/31/2016
- **Quarter End Date:** 03/31/2016
- **DSRIP Reporting Year and Quarter:** DY1 Q4

### Task 15. Update, revise and finalize NCI PPS VBP Baseline Assessment.

- **In Progress**
- **Milestone:** Finalize PPS VBP Baseline Assessment
- **Start Date:** 04/01/2015
- **End Date:** 03/31/2016
- **Quarter End Date:** 03/31/2016
- **DSRIP Reporting Year and Quarter:** DY1 Q4

### Milestone #5

- **Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest.**

- **In Progress**
- **This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board**
- **Start Date:** 04/01/2015
- **End Date:** 12/31/2016
- **Quarter End Date:** 12/31/2016
- **DSRIP Reporting Year and Quarter:** DY2 Q3

### Task 1. Analyze health care bundle populations and total cost of care data provided by the NYS Department of Health (DOH), to identify VBP opportunities that are more easily attainable and prioritize services moving into VBP.

- **In Progress**
- **Milestone:** Prioritize potential opportunities and providers for VBP arrangements.
- **Start Date:** 04/01/2015
- **End Date:** 09/30/2016
- **Quarter End Date:** 09/30/2016
- **DSRIP Reporting Year and Quarter:** DY2 Q2

### Task 2. Identify VBP accelerators and challenges within NCI PPS related to the implementation of the VBP model, including existing ACO and MCO models with current VBP arrangements, existing bundled payments, or shared savings arrangements, and necessary IT infrastructure that can be utilized to monitor VBP activity (accelerators); and contracting complexity, limited infrastructure with experience in VBP or abundance of low performing providers (challenges).

- **In Progress**
- **Milestone:** Prioritize potential opportunities and providers for VBP arrangements.
- **Start Date:** 04/01/2015
- **End Date:** 06/30/2016
- **Quarter End Date:** 06/30/2016
- **DSRIP Reporting Year and Quarter:** DY2 Q1

### Task 3. Align providers and PCMHs to potential VBP accelerators and challenges to identify which

- **In Progress**
- **Milestone:** Prioritize potential opportunities and providers for VBP arrangements.
- **Start Date:** 04/01/2015
- **End Date:** 06/30/2016
- **Quarter End Date:** 06/30/2016
- **DSRIP Reporting Year and Quarter:** DY2 Q1
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

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<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
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<tbody>
<tr>
<td>Task 1</td>
<td>In Progress</td>
<td>Milestone: Prioritize potential opportunities and providers for VBP arrangements.</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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</tr>
<tr>
<td>Task 2</td>
<td>In Progress</td>
<td>Milestone: Prioritize potential opportunities and providers for VBP arrangements.</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 3</td>
<td>In Progress</td>
<td>Milestone: Prioritize potential opportunities and providers for VBP arrangements.</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
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<tr>
<td>Task 4</td>
<td>In Progress</td>
<td>Milestone: Develop timeline for VBP adoption.</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 5</td>
<td>In Progress</td>
<td>Milestone: Develop timeline for VBP adoption.</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
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<tr>
<td>Task 6</td>
<td>In Progress</td>
<td>Milestone: Develop timeline for VBP adoption.</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
</tr>
</tbody>
</table>

providers and PCMHs are best aligned to expeditiously engage in VBP arrangements.

Task 4. Identify providers and PCMHs within the PPS with the greatest ability to negotiate VBP arrangements and operate in a VBPO model. Providers and PCMHs will be divided into three categories (Advanced, Moderate and Low) based on 1) findings derived from the VBP Baseline Assessment, 2) their alignment with VBP accelerators and challenges, and 3) their ability to implement VBP arrangements for more easily attainable bundles of care based on DOH provided data.

Task 5. Conduct engagement sessions between 'advanced' providers/PCMHs and MCOs to discuss the process and requirements necessary for engaging in VBP arrangements.

Task 6. Re-assess capability and infrastructure of providers and PCMHs that have been identified as 'advanced,' in order to assess for strengths and weaknesses in ability to continue as early adopters of VBP arrangements.

Task 7. Develop a realistic and achievable timeline for "Advanced" providers and PCMHs to become early adopters of VBP arrangements, taking into account findings of the baseline assessment, alignment with VBP accelerators, and ability to engage in VBP arrangements for the care bundles deemed more attainable and which are supported by DOH data.

Task 8. Allow for the recording of lessons learned from "Advanced" providers' engagement with
## Samaritan Medical Center (PPS ID: 45)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
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</thead>
<tbody>
<tr>
<td>VBP arrangements.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 9. Develop phases 2 and 3 for &quot;Moderate&quot; and &quot;Low&quot; providers and PCMHs to adopt VBP arrangements using lessons learned, and develop early planning states for advanced providers to move into Level 2 arrangements when appropriate.</td>
<td>In Progress</td>
<td>Milestone: Develop timeline for VBP adoption.</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 10. Engage key financial stakeholders from MCOs, PPS and providers to discuss options for shared savings and funds flow. Key elements of this step will include effectively analyzing provider and PPS performance, methods of dispersing shared savings and infrastructure required to support performance monitoring and reporting.</td>
<td>In Progress</td>
<td></td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 11. Collectively review the VBP Adoption Plan with the PPS.</td>
<td>In Progress</td>
<td>Milestone: Finalize VBP Adoption Plan</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #6</strong></td>
<td>In Progress</td>
<td>Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation</td>
<td>10/01/2019</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
<td>YES</td>
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<tr>
<td><strong>Milestone #7</strong></td>
<td>In Progress</td>
<td>Contract 50% of care-costs through Level 1 VBPs, and &gt;= 30% of these costs through Level 2 VBPs or higher</td>
<td>10/01/2019</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Milestone #8</strong></td>
<td>In Progress</td>
<td>&gt;=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and &gt;= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher</td>
<td>10/01/2019</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
<td>YES</td>
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Prescribed Milestones Current File Uploads

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<thead>
<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
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<tbody>
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Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finalize PPS finance structure, including reporting structure</td>
<td></td>
</tr>
<tr>
<td>Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.</td>
<td></td>
</tr>
<tr>
<td>Finalize Compliance Plan consistent with New York State Social Services Law 363-d</td>
<td></td>
</tr>
<tr>
<td>Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.</td>
<td></td>
</tr>
<tr>
<td>Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest</td>
<td></td>
</tr>
<tr>
<td>Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation</td>
<td></td>
</tr>
<tr>
<td>Contract 50% of care-costs through Level 1 VBPs, and &gt;= 30% of these costs through Level 2 VBPs or higher</td>
<td></td>
</tr>
<tr>
<td>&gt;=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and &gt;= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher</td>
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</table>

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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.

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

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<th>Milestone Name</th>
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<th>Description</th>
<th>Upload Date</th>
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**PPS Defined Milestones Narrative Text**

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<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
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No Records Found
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.

There are challenges to implementing the organizational strategies required for the financial sustainability work stream that could impact the PPSs efforts to assess and monitor the financial health of the PPS. These challenges include:

- Implementation of a financial reporting infrastructure
- Obtaining buy-in of the NCI PPSs DSRIP project and funds plans
- Inability to access data to perform or validate analytics related to project performance
- Failure of PPS providers to meet the DSRIP reporting requirements
- Fee for service transition to VBP
- Implementation of ICD 10

The IT current state assessment identified varying levels of financial reporting capability. A shared reporting infrastructure is essential to having timely access to the financial metrics needed to monitor the financial health of the PPS. This is therefore a key risk for the PPS's Finance Function and they will be involved in the IT Function's implementation and management of a shared IT infrastructure throughout the network. In addition, links to sources of performance data will enable the PPS finance function to have timely access to both financial and performance data to identify trends that might negatively impact the PPS and to implement plans of corrective action.

The ability to receive financial metrics for PPS providers related to financial health, the timely reporting of data and metrics related to project status and performance is essential to meeting the PPS's DSRIP reporting requirements. The NCI will need to develop a Data and Technology work plan specifically related to the requirements that the finance function for DSRIP project metrics. In addition, NCI will distribute a Finance Calendar to all PPS providers regularly to ensure partners understand the schedule for reporting information to the PPS as needed for submission to DOH.

Transitioning away from a fee-for-service reimbursement methodology toward a VBP model mitigation: create opportunities to obtain outside expertise for education and outreach through beginning with small wins. As NCI identified previously, NCI will engage partners to develop a flexible, multi-phased approach that enables the most effective method of VBP contracting. To address the complexities of VBP, the NCI will embrace the strong relationships that exist between individual providers and MCOs and will enable our providers to contract directly with MCOs in our region. To successfully operate in a VBP arrangement, our partners must maintain a firm understanding of the varying degrees of risk sharing, capitation and fee for service. NCI will examine opportunities for standardization in contracting methodologies among MCOs, ultimately streamlining our and our partner's ability to establish VBP arrangements.

Implementation of ICD-10 coding in October 2015 may temporarily shift provider priorities, as payments to providers hinges on accurate coding. Time and resources will need to be spent to train and prepare practices for this conversion, otherwise, practices could experience a potentially devastating loss of productivity and revenue. ICD 10 Risk Mitigation: a) Establish a group to assess and monitor ICD-10 provider readiness and its potential impact on the implementation of chosen projects b) Develop contingency plan in the event that provider focus shifts to ICD-10
**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.)

---

During NCI's preliminary assessment of the finance function for the NCI PPSs DSRIP application a number of interdependencies were identified with other work streams in the following key areas:

1. **Governance** – A fully supportive governance process is essential to establishing the role of the NCI Finance Function. Fully established roles within the governance structure for Finance, Compliance and Audit will inform and drive the finance committee charter, its oversight of the finance function and approach to funds flow.

2. **DSRIP Network Capabilities and Clinical Integration** - The successful implementation of the NCI's value based reform strategy, and execution of value based contracts, will require a developed and functioning integrated delivery network and buy-in of the network partners to the value based payment strategy.

3. **Performance Monitoring** – The DSRIP process has extensive reporting requirements linked to DSRIP payments – such as the quarterly reporting is a dependency for receiving DSRIP Process Payments. This reporting is dependent upon input and submission of reports and data from the individual network providers as well as other sources of data that will require the PPS's IT function to access.

4. **DSRIP Projects** – The NCI PPS finance function must have an understanding of projects selected and participation level of providers for each (Provider Participation Matrix) in order to develop a meaningful funds plan for the PPS. In addition, the PPS and the providers must understand project costs, impacts and other needs as part of their process of evaluating financial stability and impact going forward.

5. **IT Systems & Processes** – This work stream will be essential to providing technology to access data and to implement shared financial reporting infrastructure that is needed by NCI as well as the technology for reporting project level performance data that is closely linked to the payments received for DSRIP projects.

6. **Workforce** – The impact of the DSRIP projects is still being reviewed as is the costs related to those impacts and the strategies of the PPS and each provider to mitigate that impact. NCI will work closely with the workforce work stream to ensure that the appropriate data related to the workforce strategy and impact is being gather and reported to meet the DSRIP requirements. NCI is responsible for communicating these requirements for tracking and reporting to all PPS providers to ensure that the PPS meets its requirement to report this information to DOH.
### IPQR Module 3.5 - Roles and Responsibilities

**Instructions:**

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCI Payer/Finance Committee</td>
<td>Multi-Organization</td>
<td>Development of Financial Strategies, including funds flow and VBP.</td>
</tr>
<tr>
<td>Lead Entity Chief Financial Officer</td>
<td>Sean Mills</td>
<td>Responsible for the day-to-day oversight of operations of the accounts payable and banking functions, including updating policies and procedures, monitoring the accounts payable system, and developing protocols around reporting and AP check write related to the DSRIP funds distribution. This function includes the maintenance of financial records for reports.</td>
</tr>
<tr>
<td>NCI Financial Officer</td>
<td>Unknown at this time. Responsibilities will be fulfilled by Lead Entity CFO and NCI Director until determined.</td>
<td>Responsible for development and management of the Financial objectives. Provides support for Finance/Payer Committee. The individual will provide guidance and oversight around the Funds Flow Plan, the Financial Stability Plan, and other relevant processes. The responsibilities include ensuring that funds are managed and distributed according to the approved plan, that reporting requirements are met and that communication regarding the Finance related functions is timely and accurate.</td>
</tr>
<tr>
<td>NCI DSRIP Compliance Officer</td>
<td>TBD will be filled by the Lead Entity Compliance Officer in the interim</td>
<td>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 compliance role will report to the Executive Body.</td>
</tr>
<tr>
<td>NCI Compliance Committee</td>
<td>Multi-Organization</td>
<td>Responsible to ensure Compliance programs are in place</td>
</tr>
<tr>
<td>Lead Entity Compliance Officer</td>
<td>Barbara Morrow</td>
<td>Will fill Compliance Officer role is completed until NCI Compliance Officer is in place. Will provide oversight to NCI Compliance Officer</td>
</tr>
<tr>
<td>NCI Director</td>
<td>Brian Marcolini</td>
<td>Overall NCI Leadership. Coordinate overall development of VBP baseline assessment and plan for achieving value based payments. Coordinate approach and engagement of process to develop PPS VBP Baseline Assessment and Adoption Plan. Ultimately responsible for the development of the PPS VBP Baseline Assessment and Adoption Plan.</td>
</tr>
<tr>
<td>Role</td>
<td>Name of person / organization (if known at this stage)</td>
<td>Key deliverables / responsibilities</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>NCI Project Management Officer</td>
<td>Ray Moore</td>
<td>Will ensure the tracking of partner performance for DSRIP performance payments</td>
</tr>
<tr>
<td>NCI Financial Consultant</td>
<td>TBD</td>
<td>Will assist with Financial analysis and financial sustainability plans and the development of financial metrics</td>
</tr>
<tr>
<td>NCI Data Analyst</td>
<td>Jeff Bazinet</td>
<td>Will ensure data plan to support DSRIP payments, value-based payment and financial metrics is in place</td>
</tr>
<tr>
<td>Auditor</td>
<td>TBD</td>
<td>External auditors reporting to the Finance Committee. The firm will perform the audit of the PPS and PPS Lead related to DSRIP services according to the audit plan approved by the Finance Committee and Executive Body</td>
</tr>
</tbody>
</table>

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### IPQR Module 3.6 - Key Stakeholders

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

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Applicant/Entity</td>
<td>North Country Initiative, LLC with Samaritan as Lead</td>
<td>Policy and Funds Flow Development, Oversight and Responsibility for All DSRIP</td>
</tr>
<tr>
<td>Major Safety Net hospital partners</td>
<td>Samaritan Medical Center, River Hospital, Claxton-Hepburn Hospital, Clifton-Fine Hospital, Massena Memorial Hospital, Carthage Area Hospital</td>
<td>Financial Sustainability Plans, Participation in committee sand financial and value-based planning functions as applicable</td>
</tr>
<tr>
<td>All PPS Partners</td>
<td>Actively carry out deliverables to ensure funds flow plan implemented</td>
<td>Financial Sustainability Plans, Participation in committees and financial and value-based planning functions as applicable</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Drum Regional Health Planning Organization</td>
<td>Financial Plan Assistance IT infrastructure Contracted PMO Staffing and Support Coordination of Activities</td>
<td>IT/Data Partnership Facilitation of Activities Continuity &amp; Credibility</td>
</tr>
<tr>
<td>Managed Care Organizations</td>
<td>MCCs identified by PPS for pursuit of PPS Value based reform strategies</td>
<td>The PPS Lead and PPS will have responsibilities related to implementing the PPSs value based strategy</td>
</tr>
<tr>
<td>Non-Partner Community Based Organizations</td>
<td>Engagement and Recipients of communication plans.</td>
<td>Understanding and buy-in</td>
</tr>
<tr>
<td>Medicaid and Uninsured Patients, Community Members</td>
<td>Engagement to ensure positive impact on beneficiaries. Recipients of communication plans.</td>
<td>Information to ensure projects and activities are effective and appropriately targeted</td>
</tr>
</tbody>
</table>
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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 development of shared IT infrastructure across the NCI PPS will support the NCI Finance Officer and the financial sustainability of the network by providing the network partners with capability for sharing and submitting reports and data pertaining to project performance and other DSRIP related business in a secure and compliant manner. The NCI has begun the process of establishing a shared reporting platform across the network, which will be utilized to provide access and visibility to updates on key financial sustainability metrics at the provider and PPS level. The NCI also intends to link to the performance reporting mechanisms that will be utilized across the PPS to provide the NCI DSRIP Finance Committee with current data that may be utilized to track project performance levels and expected DSRIP payments.

Other shared IT infrastructure and functionality across the PPS that will support or contribute to the success of the NCI PPS Finance function includes:

• Population Health systems or technology that will support the need to access and report on data related to clinical services and outcomes – for DSRIP required metrics and to meet the needs under value based payment arrangements.
• Care Coordination technology and systems that supports broad network integration of services and health management capabilities.

IPQR Module 3.8 - Progress Reporting

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

The NCI will align our PPS financial management and sustainability progress reporting with the reporting and oversight structures in place for the DSRIP projects, through the NCI PPS Project Management Office. The PMO will be responsible for monitoring progress against project requirements and process measures at a provider level, and the preparation of status reports for the quarterly reporting process for DOH.

The PMO will be utilizing (Performance Logic) a project management performance based software platform for monitoring, controlling and reporting (weekly, monthly, quarterly) status / metrics associated with project milestones / deliverables. Performance Logic is specifically designed to the needs of the PPS with project management, implementation, planning, performance monitoring and results oriented project tracking / reporting. Performance Logic incorporates all aspects of DSRIP tracking enhancing NCI's ability to communicate with multiple team members and essential stakeholders.

The NCI will integrate into this process the financial reporting required to monitor and manage the financial health of the network over the course of the DSRIP program. The NCI PPS Finance Officer will be responsible for consolidating all of the specific financial elements of this project reporting.
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into specific financial dashboards for the NCI PPS Board and for the tracking of the specific financial indicators the PPS is required to report on as part of the financial sustainability assessments and the ongoing monitoring of the financial impacts of DSRIP on the providers. Through ongoing reporting, if a partner trends negatively or if the financial impacts are not in line with expectations, the NCI PPS Finance Officer will work with the NCI Finance Committee to engage the provider to understand the financial impact and develop plans for corrective action.

The NCI Finance Officer will provide regular reporting to the Lead Entity, the Finance Committee, Executive Body and network partners as applicable regarding the financial health of the NCI PPS and updates regarding the Financially Fragile Watch List and the Distressed Provider Plans currently in place.

IPQR Module 3.9 - IA Monitoring

Instructions:
## Section 04 – Cultural Competency & Health Literacy

### IPQR Module 4.1 - Prescribed Milestones

Instructions:

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

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td>In Progress</td>
<td>Finalize cultural competency / health literacy strategy.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Task 1</strong></td>
<td>In Progress</td>
<td>Identify priority groups experiencing health disparities (based on PPS CNA and other analyses)</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td><strong>Task 2</strong></td>
<td>In Progress</td>
<td>Identify key factors to improve access to quality primary, behavioral health, and preventive health care</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td><strong>Task 3</strong></td>
<td>In Progress</td>
<td>Define plans for two-way communication with the population and community groups through specific community forums</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task 4</strong></td>
<td>In Progress</td>
<td>In collaboration with care management</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>teams, identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors)</td>
<td>In Progress</td>
<td>See Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task 5</strong> - In collaboration with Population Health Improvement Committee/workgroups identify community-based interventions to reduce health disparities and improve outcomes</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task 6</strong> - In collaboration with community members and following a review of evidence-based strategies, evaluate the adequacy of the CC &amp; HL strategy and make any required adjustments</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task 7</strong> - Incorporate evaluation plan into CC &amp; HL strategy. Evaluation plan to include CAHPS Health Literacy Measure as identified in DSRIP Measure specification guide and to include target population improvement in outcomes responsive to self-management</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task 8</strong> - Incorporate Health Literacy and Cultural Competency plan into NCI Communication Plan in partnership with FDRHPO community based Communication Committee</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Task 9</strong> - Cultural competency / health literacy strategy signed off by PPS Board.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #2</strong> Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).</td>
<td>In Progress</td>
<td>This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td>YES</td>
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</table>
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)  

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task 1 - Engage community-based partners with expertise for sub-committee and incorporate into governance structure</strong></td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task 2 - In collaboration with workforce workgroup develop training plan for clinicians, focused on available evidence-based research addressing health disparities for particular groups</strong></td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task 3 - In collaboration with workforce workgroup develop training plans for other segments of the NCI workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches</strong></td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task 4 - Cultural Competency and Health Literacy training strategy adopted by board</strong></td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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Prescribed Milestones Current File Uploads

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<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
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<tbody>
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Prescribed Milestones Narrative Text

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

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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.

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

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

**PPS Defined Milestones Narrative Text**

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<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>
New York State Department Of Health
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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: Perception of importance by providers and stakeholders |
| Mitigation: Identify Peer Champions, utilize a stratified level of intensity with training appropriate and targeted to population served so value is reinforced by improved patient compliance |
| Risk 2: Understanding of health literacy and the provider role |
| Mitigation: Incorporation into overall communication plan/messaging so message is consistently reinforced, use of empirical studies that illustrate effect of health literacy on patient compliance |
| Risk 3: Clinician availability/time to take training |
| Mitigation: Align with other training and schedule of training, make training available in multiple formats, stratify level of intensity of training based on level of risk of patient population served |
| Risk 4: Provider Training overload with multiple DSRIP, ACO and other Clinical Integration requirements |
| Mitigation: Align to consolidate and reinforce efforts |
| Risk 5: Technology limitations for online trainings |
| Mitigation: Identification of limitations and resources available to conduct training |
| Risk 6: Willingness of agencies to adopt policy drafts adopted by board |
| Mitigation: Communication Plan regarding all DSRIP activities includes Health Literacy and Cultural Competency. Inclusion of Health Literacy and Cultural competency in contractual participation requirements |

☑ 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.)

1. Governance: NCI Governance will need to adopt health literacy and cultural competency strategy and training plan and will need to incorporate health literacy and cultural competency policies.
2. Workforce: Health Literacy will need to be included as a core component in workforce training strategy so it is critical for the Health Literacy and Cultural Competency Committee work interface closely with the Workforce Committee
3. Practitioner Engagement, Clinical Projects, Clinical Integration and Care Coordination: If Clinical outcomes are to be met and care coordination is to meet its goals than the patient must be engaged and able to clearly understand the information provided to them. Also health literacy and cultural competency are a component of PCMH. Therefore health literacy and cultural competency must be recognized for its importance in the clinical work stream.

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4. IT Systems & Processes: Technology provides an efficient means to train multiple people at disparate geographic locations and must be utilized if the PPS is to be successful given the rural geography. Further technology will need to be able to track the training completion and support performance monitoring of improvements in patient outcomes.

5. Population Health Management: PHM tools can only be effective if their use drives health behavior change for patients through engagement. If patients do not understand and engage in their care than PHM fails.

6. Patient Engagement: Patients cannot be engaged in their own care if they do not understand the care instructions being given to them or if they do not have the skills and or tools to carry out the instructions.
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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.

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
</table>
| NCI Health Literacy and Cultural Competency Committee | Aileen Martin, NRCIL  
Korin Scheible, MHA  
Natalie Burnham, CAH  
Larry Calkins, SVP  
Jennie Flanagan, CH  
Ian Grant, FDRHPO  
April Halliday, FDRHPO  
Rachel Holmes, SMC  
Stefanie Jones, SBS  
Tracy Leonard, FDRHPO  
Faith Lustik, JCPHS  
Cindy Nelson, River  
Andrea Pfeiffer, River  
Jeff Reifensnyder, MIL  
Denise Young, FDRHPO | 1. Identify vulnerable groups facing health disparities  
2. Identify strategy to improve access to primary, BH, and preventive care  
3. Define plans for two-way communication between community and CBOs via open forums  
4. Identify community-based interventions to reduce health disparities and improve outcomes  
5. In collaboration with care management teams, identify tools to assist patients with disease self-management  
6. Approve and submit Cultural Competency/Health Literacy strategy to PPS Board  
7. In collaboration with workforce committee, develop training plan for clinicians, integrating evidence-based tools to address health disparities for specific groups  
8. In collaboration with workforce committee, develop training plan for allied health professionals regarding unique population needs and effective patient engagement tools  
9. Approve and submit Cultural Competency/Health Literacy training strategy to NCI board  
10. Provide oversight, monitor implementation, evaluate strategy and training |
| HL&CC Committee Facilitator | Aileen Martin | Facilitate HH & CC Committee Activities |
| NCI Program Manager | Celia Cook | Serve as Liaison between Communication Planning Committee and HH & CC Committee |
| Workforce & Care Management Liaison | Tracy Leonard | Serve as Liaison between Workforce & Care Management Committees and HH & CC Committee |
| CBOs with HH Expertise | NRCIL, MHA, MIL, SBS, JCPH, SVP & others as identified | Serve as facilitators and engagers with disparate populations and targeted providers |
Instructions:
Please identify the key stakeholders involved, both within and outside the PPS.

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCI Board of Managers</td>
<td>Board Members</td>
<td>Review and adopt policies</td>
</tr>
<tr>
<td>NCI Communication Committee</td>
<td>Include HH &amp; CC in Communication Plan</td>
<td>Communication Plan that addresses HH &amp; CC</td>
</tr>
<tr>
<td>NCI Director</td>
<td>Responsible for overall oversight of all NCI Activities</td>
<td>Ensure that all workstreams endorse and adopt HH&amp;CC Policies as applicable</td>
</tr>
<tr>
<td>NCI Care Management Committee</td>
<td>Include HH &amp; CC in Care Management Plan</td>
<td>Care Management Plan that addresses HH &amp; CC</td>
</tr>
<tr>
<td>Safety Net hospital partners</td>
<td>Adopt HH&amp;CC Policies</td>
<td>Trained staff, implemented policies to impact improved patient outcomes for disparate populations</td>
</tr>
<tr>
<td></td>
<td>Implement HH &amp; CC Training as applicable</td>
<td></td>
</tr>
<tr>
<td>All PPS Partners</td>
<td>Adopt HH&amp;CC Policies</td>
<td>Trained staff, implemented policies to impact improved patient outcomes for disparate populations</td>
</tr>
<tr>
<td></td>
<td>Implement HH &amp; CC Training as applicable</td>
<td></td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Drum Regional Health Planning Organization</td>
<td>Contracted PMO staffing and Support, Coordination of Activate Community Based Engagement</td>
<td>Facilitation of Activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Analytics to identify disparate Hot Spots</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continuity &amp; Credibility for Community Engagement with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Population Health Improvement Program and other Community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Based programs that engage disparate populations</td>
</tr>
<tr>
<td>Non-Partner Community Based Organizations</td>
<td>Engagement</td>
<td>Understanding and buy-in</td>
</tr>
<tr>
<td></td>
<td>Potential to provide service</td>
<td></td>
</tr>
<tr>
<td>Medicaid and Uninsured Patients, All Population</td>
<td>Participation in neighborhood and community engagement activities, potential community health worker roles of the future</td>
<td>Information to ensure projects and activities are effective and appropriately targeted</td>
</tr>
<tr>
<td>for Population Health Projects</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IPQR Module 4.7 - IT Expectations

Instructions:

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

North Country Initiatives, ability to obtain information quickly on a patient’s health, health care, and potential treatments is critically important. Additionally, the ability to share this information in a timely manner with other providers caring for the patient and the patient themselves is essential to the delivery of safe, patient-centered, coordinated, and efficient health care. To meet this need, collaboration across the entire PPS is underway to develop and leverage: electronic health record (EHR) systems with decision support for clinicians, a secure platform for the exchange of patient information across health care settings, Patient portals for patient engagement in their own care and data standards that will make shared information understandable to all users. Efforts are also underway to complete the implementation of a population health management tool that will allow our PPS to analyze, and aggregate real time data on our participants and those beneficiaries who do not opt out. NCI's PPS will not be successful within DSRIP or any other Healthcare reform initiative if our information technology cannot produce reports on our ability to deliver safe, effective, patient-centered, timely health care. Those reports will be allow our PPS to take data and turn that information into healthcare decisions such as where to focus our Health Literacy and Cultural Competency efforts which will allow for improved patient outcomes and a reduction in healthcare cost for the region. In addition, technology will be utilized to monitor and track training activities across the PPS.

IPQR Module 4.8 - Progress Reporting

Instructions:

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

The success of North Country Initiative Health Literacy and Cultural Competency Strategy will be ultimately measured by the PPSs ability to engage the patient population in managing their own care and in striving for health and thus achieving 1) reductions in unnecessary exacerbation of existing conditions resulting in ED and inpatient utilization and 2) the avoidance of disease onset/development. The process measures leading to this outcome will be the boards adoption of the Health Literacy and Cultural Competency Strategy and the Health Literacy and Cultural Competency Training Strategy, the numbers of providers and front-line workers trained, the number/percentage of partners to adopt policies, and the development and ongoing review of health education tools to meet the targeted populations needs. All of these measures and Metrics will be monitored by the PMO.

North Country Initiative (NCI) has established a Project Management Office (PMO) staffed with a certified Project Management Officer and Program Manager. The PMO will be utilizing (Performance Logic) a project management performance based software platform for monitoring, controlling and reporting (weekly, monthly, quarterly) status / metrics associated with project milestones / deliverables. Performance Logic is specifically designed to the needs of the PPS with project management, implementation, planning, performance monitoring and results oriented...
project tracking / reporting. Performance Logic incorporates all aspects of DSRIP tracking enhancing NCI's ability to communicate with multiple team members and essential stakeholders.

**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.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td>In Progress</td>
<td>Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>Assemble a team to do the assessments and establish a governance committee to oversee the progress and evaluate results.</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>1. Finalize the assessment team membership to include the NCQA Certified Content Experts (CCE) for the PCMH portion, the PPS Privacy and Security Officer for the security portion, the HIT specialists for the MU portion and an HealtheConnections implementation Specialist for the HIE portion. This team will report to the PPS/Regional CIO - Corey M. Zeigler</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>Develop an assessment tool to gather, evaluate and report findings</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>2. Finalize the assessment tool to include PCMH, Privacy and Security, EHR utilization, including Meaningful Use (MU) and</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**  

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<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>interoperability capabilities to connect to the HIE.</td>
<td><strong>Task</strong></td>
<td>3. Conduct IT Readiness assessment and analyze results (survey to include readiness for data sharing at the provider level and a mapping of the various systems in use throughout the network and their potential interoperability)</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task 3a. Assess Specialty Practices for IT Readiness</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 3b. Assess Primary Care Clinics/Practices for IT and PCMH Readiness</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 4. Produce a regional report for the governance committee and individual organizational report for the participant</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 5. Update and approve IT Strategic Plan</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 6. Map future state needs articulated in IT Strategic Plan against readiness assessment in order to identify key gaps in IT infrastructure, data sharing and provider capabilities</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
</tbody>
</table>

**Milestone #2**  
**Develop an IT Change Management Strategy.**  

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  

| Task 1. Develop Communication and Change Management Stakeholder List | In Progress | See Task | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 |
| Task | In Progress | See Task | 04/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2 |

**NYS Confidentiality – High**
<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Define IT Change Approval Process (by Designated Authorities)</td>
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<tr>
<td>Task 3. Establish roles, responsibilities, and performance metrics for change process</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Task 4. Develop a risk assessment tool</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td>Task 5. Conduct a risk assessment and mitigation plan</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Task 6. Develop a change management process and tracker</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 7. Develop Communication and Change Management Plan</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
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<tr>
<td>Task 8. Develop Education and Training Plan</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 9. Identify, communicate, and escalate pathways for Change Advisory Board, representing multiple entities</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 10. Approve and publish IT Change Strategy (including risk management), signed off by the NCI Board</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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</tbody>
</table>

**Milestone #3**

Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network

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

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

Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 1</td>
<td>In Progress</td>
<td>Establish Interoperability Governance responsibility with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 2</td>
<td>In Progress</td>
<td>Define data exchange needs based on the planning for the 11 DSRIP Projects and engagement with the network providers (as part of the current state assessment)</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 3</td>
<td>In Progress</td>
<td>Define system interoperability requirements, using HIE/RHIO Protocols (Performance, Privacy, Security, etc.)</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 4</td>
<td>In Progress</td>
<td>Map current state assessment against data exchange and system interoperability requirements</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 5</td>
<td>In Progress</td>
<td>Develop a plan to execute and track data sharing agreements</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 6</td>
<td>In Progress</td>
<td>Incorporate Data Sharing Consent Agreements and Consent Change Protocols into partner agreements, including subcontractor DEAAs with all providers within the PPS; contracts with all relevant CBOs</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 7</td>
<td>In Progress</td>
<td>Develop a governance framework and plan to share clinical data including agreed upon technical standards and clinical data set(s)</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 8</td>
<td>In Progress</td>
<td>Evaluation of business continuity, and data privacy controls by IT Governance Committee</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 9</td>
<td>In Progress</td>
<td>Develop transition plan for providers currently using paper-based data exchange and workarounds where full interoperability is not</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<tr>
<td>Milestone/Task Name</td>
<td>Status</td>
<td>Description</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
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<td>feasible.</td>
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<tr>
<td>Task 10. Develop training plan for front-line and support staff, targeting capability gaps identified in current state assessment</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
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<tr>
<td>Task 11. Finalize clinical data sharing and interoperability roadmap and report to the PPS/Regional CIO - Corey M. Zeigler</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 11a. Roadmap should include steps necessary to achieve interoperable systems throughout the network, steps toward developing acceptable workarounds where full interoperability is not feasible within PPS project timelines, monitoring of progress in data sharing capability, and the steps necessary toward the development, negotiation, and execution of appropriate data agreements.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Milestone #4</td>
<td></td>
<td>PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td>NO</td>
</tr>
<tr>
<td>Task 1. Establish patient engagement/consent governance responsibility</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 2. Identify system needs, interfaces, and Action Plans for Existing/New Attributed Members</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 3. In partnership with the Communication Committee perform a Gap analysis of existing communication channels used to engage with patients (Call, Text, Mail Etc.), comparing this to demographic information about member population (using CNA)</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
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<tr>
<td>Task 4. Establish new patient engagement channels, potentially including new infrastructure (Portal,</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
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</table>
### Milestone/Task Name

- **Task 5.** Incorporate patient engagement metrics (including numbers signing up to QEs) into performance monitoring for NCI and establish reporting relationship (focused on this metric) with NCI PPS PMO
  - Status: In Progress
  - Description: See Task
  - Start Date: 04/01/2015
  - End Date: 06/30/2016
  - Quarter End Date: 06/30/2016
  - DSRIP Reporting Year and Quarter: DY2 Q1

- **Task 5a.** Develop plan for engaging patients in the appropriate care setting and ensuring they are presented with a RHIO Consent form
  - Status: In Progress
  - Description: See Task
  - Start Date: 04/01/2015
  - End Date: 06/30/2016
  - Quarter End Date: 06/30/2016
  - DSRIP Reporting Year and Quarter: DY2 Q1

- **Task 6.** Establish patient engagement progress reporting to NCI PPS PMO
  - Status: In Progress
  - Description: See Task
  - Start Date: 04/01/2015
  - End Date: 06/30/2016
  - Quarter End Date: 06/30/2016
  - DSRIP Reporting Year and Quarter: DY2 Q1

- **Task 7.** Develop a written reporting plan to keep the board updated on the progress of engaging the patients in the QE (RHIO).
  - Status: In Progress
  - Description: See Task
  - Start Date: 04/01/2015
  - End Date: 06/30/2016
  - Quarter End Date: 06/30/2016
  - DSRIP Reporting Year and Quarter: DY2 Q1

### Milestone #5

**Develop a data security and confidentiality plan.**

- Status: In Progress
- Description: 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.
- Start Date: 04/01/2015
- End Date: 03/31/2016
- Quarter End Date: 03/31/2016
- DSRIP Reporting Year and Quarter: DY1 Q4
- AV: NO
<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 4. Data Security Audit or Monitoring Plan Established</td>
<td>In Progress</td>
<td><strong>Task 4a.</strong> The Data Security Audit or Monitoring Plan will include periodic and spot-check audits, executed Business Associate Agreements (BAA) and annual privacy and security assessments to ensure compliance within the network with all HIPAA privacy and IT security requirements. The participating entities will be required to implement appropriate training programs, risk assessments, and controls to mitigate risks to the integrity and security of PHI.</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task 5. Identify Vulnerability Data Security Gap Assessment and implement Mitigation Strategies</td>
<td>In Progress</td>
<td><strong>Task 5a.</strong> Based on the assessments, develop plans for ongoing security mitigation, including testing and monitoring.</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task 6. Create on-going Data Security Progress Reporting to IT Governance Committee</td>
<td>In Progress</td>
<td><strong>Task 5b.</strong> Create on-going Data Security Progress Reporting to IT Governance Committee.</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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**Prescribed Milestones Current File Uploads**

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<th>Description</th>
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**Prescribed Milestones Narrative Text**

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<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>Perform current state assessment of IT</td>
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### Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).</td>
<td></td>
</tr>
<tr>
<td>Develop an IT Change Management Strategy.</td>
<td></td>
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<tr>
<td>Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network</td>
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</tr>
<tr>
<td>Develop a specific plan for engaging attributed members in Qualifying Entities</td>
<td></td>
</tr>
<tr>
<td>Develop a data security and confidentiality plan.</td>
<td></td>
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</table>
**IPQR Module 5.2 - PPS Defined Milestones**

Instructions:

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

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

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</table>
The major risks to the IT Systems and Processes are; the disparity in systems and competing priorities. Given these risks, the NCI went through a series of meetings and identified appropriate risk mitigation strategies. The following risks were ranked most significant:

Risk 1: There are still some network partners utilizing paper-based records – these providers will be immediately selecting and purchasing an EHR utilizing CRFP capital funds. If the CRFP funds are unavailable, individual entities may have to cover the investment, which they do not have the capital to do and may have to be heavily incentivized to do.

Risk 2: With so many partners in the PPS, there are extensive variations with EHR platforms, care management, and population health management systems. Our PPS is seeking financial and technological means to not only create a more standard infrastructure, but also one that will be set-up to meet the PCMH 2014 Level 3 standards by DY3. There is a critical need for a regional registry/PHM, which is currently under development – the PPS will hire 2 reporting analysts to accelerate the implementation and meet the reporting demands that are not supplied by the MAPP tool. The risks related to lack of standardization can also be mitigated by forming workgroups around common issues and initiatives that report up to an advisory group. The risks to effectively integrating care will also be hampered by the state and federal regulations that control what can be shared with whom and for how long, which will be a challenge to accommodate with current technologies. Some of this has been addressed with waivers, but others, especially the federal regulations will require further investigation and possibly additional investments in technology. In addition the PPS will engage a proven resource with extensive PCMH and Practice transformation experience to assist all providers.

Risk 3: Data Security Measures may not be in place. Although we are confident that our partners who have or will be signing data agreements will continue to ensure data security measures are in place, in order to mitigate data security risks, we will work with our partners to perform security audits and mitigate any issues that may arise from those audits. The risks can also be mitigated though a common technical, administrative and physical security framework developed, approved and adopted by all participants.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

It cannot be over stated that all projects and workstreams are dependent in the IT Systems & Processes. As is described throughout this implementation plan, the development of new and/or improved IT infrastructure is a crucial factor underpinning all other workstreams including, in particular, clinical integration, population health management and performance reporting. However, without the right business and financial support, the North Country Initiative (NCI) PPS will not be able to drive the technological infrastructure development program to ensure the success of these workstreams. The interaction between the NCI and the PPS's clinical governance structure (especially the Practitioner
Champions) will be vital to ensure that the IT infrastructure developed meets the needs of individual practitioners, providers and – particularly when it comes to population health management – the whole PPS network. During development of the IT future state, NCI will work closely with the NCI Finance Team to review available capital and DSRIP funding resources. Adding new technologies, interfaces, reporting and monitoring solutions, and other engagement channels within our PPS will also require additional IT/practice transformation staffing, which will depend heavily on the NCI Workforce Strategy team. The PPS will need additional resources for IT support, analysis, and reporting. Along with the need for new IT staff and systems, training the workforce to use new and expanded systems effectively will be crucial.
### IPQR Module 5.5 - Roles and Responsibilities

**Instructions:**

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional CIO</td>
<td>Corey M. Zeigler</td>
<td>Executed/approved plans</td>
</tr>
<tr>
<td>Data, Infrastructure, and Security Lead</td>
<td>Chris Grieco, FDRHPO Chief Security Officer</td>
<td>Data security and confidentiality plan, Data Exchange Plan</td>
</tr>
<tr>
<td>Project Management Officer</td>
<td>Ray Moore</td>
<td>Project plans</td>
</tr>
<tr>
<td>Clinical lead(s)</td>
<td>Site Leads</td>
<td>Main driver at each participant site for clinical deliverables</td>
</tr>
<tr>
<td>Technical lead(s)</td>
<td>IT Champions</td>
<td>Main driver at each participant site for operational deliverables</td>
</tr>
<tr>
<td>Clinical Champion</td>
<td>Provider Champions</td>
<td>Main driver at each participant site for provider engagement</td>
</tr>
<tr>
<td>RHIO/HIE</td>
<td>Rob Hack, HealtheConnections RHIO</td>
<td>Delivering interoperability for the region</td>
</tr>
</tbody>
</table>
**IPQR Module 5.6 - Key Stakeholders**

Instructions:

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

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
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</tr>
<tr>
<td>Brian Marcolini, NCI Director</td>
<td>Leading the regional clinical integration</td>
<td>Clinical strategies to guide the technology(ies)</td>
</tr>
<tr>
<td>Jeff Bazinet, NCI Data Analyst &amp; Ray Moore, NCI DSRIP Project Management Officer</td>
<td>Population health management and performance reporting</td>
<td>Regional strategies to guide the technology(ies)</td>
</tr>
<tr>
<td>Charlie McArthur, FDRHPO Quality Analyst</td>
<td>Contracted assistance with Performance reporting</td>
<td>Reporting strategies to change behaviors and guide decisions</td>
</tr>
<tr>
<td>Tracy Leonard, FDRHPO Deputy Director</td>
<td>Workforce and Care Coordination Manager</td>
<td>HIT Workforce plan</td>
</tr>
<tr>
<td>Safety Net hospital &amp; all PPS Partners</td>
<td>Adopt IT Systems and Processes, Participate in governance and communication plan</td>
<td>Support staff training, implement policies and workflow changes to support IT systems and process</td>
</tr>
<tr>
<td>PPS Partner Providers</td>
<td>Support and adhere to changes in workflow</td>
<td>Participate in and support staff training, implement policies and workflow changes to support IT systems and process</td>
</tr>
<tr>
<td>PPS Partners Support Staff</td>
<td>Support and adhere to changes in workflow</td>
<td>Participate in training, implement policies and workflow changes to support IT systems and process</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Drum Regional Health Planning Organization</td>
<td>Contracted PMO staffing and Support, Coordination of Activate Community Based Engagement</td>
<td>Facilitation of Activities, Data Analytics, Continuity &amp; Credibility for Community Engagement with Population Health Improvement Program and other Community Based programs</td>
</tr>
<tr>
<td>Non-Partner Community Based Organizations</td>
<td>Engagement</td>
<td>Understanding and buy-in</td>
</tr>
<tr>
<td>Medicaid and Uninsured Patients, All Population for Population Health Projects</td>
<td>Participation in utilization of systems as enabled for patient engagement</td>
<td>Utilize health information to improve QoL and Health Outcomes</td>
</tr>
</tbody>
</table>
IPQR Module 5.7 - Progress Reporting

Instructions:

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

North Country Initiative (NCI) has established a Project Management Office (PMO) staffed with a certified Project Management Officer and Program Manager. The PMO will be utilizing Performance Logic, a project management performance based software platform for monitoring, controlling and reporting (weekly, monthly, quarterly) status / metrics associated with project milestones / deliverables. Performance Logic is specifically designed to the needs of the PPS with project management, implementation, planning, performance monitoring and results oriented project tracking / reporting. Performance Logic incorporates all aspects of DSRIP tracking enhancing NCI's ability to communicate with multiple team members and essential stakeholders. All IT metrics and measures as outlined below will be provided to the PMO and incorporated in the performance reporting.

Our IT Governance Committee has established expectations with all partners to supply key artifacts and monthly reports on key performance metrics. We will monitor the development and acquisition of key data sharing capabilities across the network and perform ongoing use and performance reports. These will be necessary to ensure continuing progress against our IT change management strategy. Follow-up specific IT questionnaires and surveys will be used periodically to identify any additional gaps, under/non-utilization, or the need for re-training. The individual partners (as applicable) will be responsible for engaging attributed members in QEs and will report on this to the PPS PMO. The HIT Advisory Committee will also report to the Medical Management Committee on the level of engagement of providers in new / expanded IT systems and processes, including data sharing and the use of shared IT platforms.

In addition, the HIT Advisory Committee will use the following ongoing performance reports to measure continuous performance of all partners:

1. Annual Gap Assessment Report – Partner adoption of IT infrastructure, enablement of clinical workflows, and application of population analytics
2. Annual refresh of IT Strategic Plan
3. Annual Data Security Audit Findings and Mitigation Plan
4. Quarterly workforce training compliance report
5. Monthly Project Portfolio ‘Earned Value’ report for all IT related projects within DSRIP project portfolio
6. Monthly HIE usage report
7. Weekly Performance report on vendor agreed SLAs

HIT Advisory Committee will also conduct a quarterly survey of IT stakeholders (in particular the users of new infrastructure / systems) to derive qualitative assessments of user satisfaction.

IPQR Module 5.8 - IA Monitoring

Instructions:

NYS Confidentiality – High
Section 06 – Performance Reporting

**IPQR Module 6.1 - Prescribed Milestones**

**Instructions:**

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

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

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td></td>
<td>Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality &amp; performance dashboards -- Your approach to Rapid Cycle Evaluation</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>NO</td>
</tr>
<tr>
<td>Task 1. Perform a current state assessment of existing reporting processes across the PPS and define target state outcomes.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 2. Utilize Performance Logic’s performance reporting systems and dashboards that provide multi-level detail for reports to the PMO, NCI Board and PPS entities. Monthly dashboard reports will accurately reflect current performance levels of the PPS. The various dashboards will be linked and will have drill-down capabilities within Performance Logic.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 3. Establish regular two-way reporting structure to govern the monitoring of performance based on both claims-based, non-hospital CAHPS DSRIP metrics and DSRIP population health metrics (using NCIs PPS-specific Performance</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
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New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tr>
<td>Measurement Portal).</td>
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<td></td>
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<tr>
<td><strong>Milestone #2</strong></td>
<td></td>
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</tr>
<tr>
<td>Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.</td>
<td>In Progress</td>
<td>Finalized performance reporting training program.</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td>NO</td>
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<tr>
<td><strong>Task 1.</strong></td>
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</tr>
<tr>
<td>Perform current state analyses to determine and design workflows associated with clinical quality and performance reporting. Identify the current workflow boundaries, understand current workflow functions and limitations; determine methods for streamlining future workflow and determine if current automations supports future state workflow and training mandates.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Task 2.</strong></td>
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<tr>
<td>Create, standardize and implement a training process for performance reporting</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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<tr>
<td><strong>Task 3.</strong></td>
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<tr>
<td>Develop and validate performance reporting training curriculum specific to reporting for the PPSs 11 DSRIP projects: 2.a.i, 2.a.ii, 2.a.iv, 2.b.iv, 2.d.i,3.a.i,3.b.i,3.c.i,3.c.ii,4.a.iii,4.b.ii</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
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<tr>
<td><strong>Task 4.</strong></td>
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</tr>
<tr>
<td>Establish a training plan to field performance reporting training at multiple sites across the PPS geographic service area</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Task 5.</strong></td>
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<tr>
<td>In collaboration with the PPS PMO, the performance monitoring training team will identify performance reporting leaders across the PPS</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

Prescribed Milestones Current File Uploads

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Prescribed Milestones Narrative Text

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<tbody>
<tr>
<td>Establish reporting structure for PPS-wide performance reporting and communication.</td>
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<tr>
<td>Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.</td>
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</tbody>
</table>
**IPQR Module 6.2 - PPS Defined Milestones**

Instructions:

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

<table>
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<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
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**PPS Defined Milestones Narrative Text**

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

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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.

Limits for the maximum degree of risk acceptable per project will be identified, documented and mitigated to reduce the degree of impact to Domain milestones / deliverables / metrics. Inclusion of all medical, behavioral, post-acute, long-term care, community-based and social service providers and payers within the PPS network to support our strategy, as measured by provider network list. The primary risk is the uncertainty of not being able to physically produce final deliverables for each project’s established speed-&-scale and detailed criteria. In order to mitigate this risk the North Country Initiative (NCI) has established a Project Management Office (PMO) staffed with a certified Project Management Officer and Program Manager. The PMO will be utilizing a project management performance based software platform to monitor, control and mitigate risks associated with project milestones / deliverables. The PPS geographical location, demographics and large coverage area present a high risk in the reform of advance care coordination, management of chronic diseases, population health management and recruiting of qualified professionals. This risk will be mitigated through improved communications, IT systems upgrades, direct Stakeholder involvement and the NCI Board’s ability to collaborate and work collectively to make informative strategic decisions and issue resolution. Prevention and Quality – The region performs poorly compared to NYS on every single Prevention Quality Indicator. In addition, both Medicaid and uninsured indicate quality of care as the main reason for leaving region for care. Existing providers must modify practice of care to address quality prevention through patient centered medical home (PCMH) and must place a strong focus on cardiac, diabetes, COPD, and mental illness and substance abuse prevention due to the prevalence of these diseases and their impact on avoidable admissions and emergency room visits. NCI will mitigate risk by monitoring clinical performance, providing feedback and incentivizing positive quality improvements.

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.)

1. Governance: Performance reporting has significant dependence on the Governance workstream. Effective stakeholder involvement and a well defined organizational structure will enhance the PPSs ability to create a value based performance oriented culture that focuses on quality healthcare and establishes clear lines of responsibilities and accountability.

2. Workforce: Performance reporting will rely heavily on the abilities of the Workforce Strategy workstream to enhance the PPSs efforts to develop a consistent performance reporting culture that captures detailed training data of training conducted across the PPS network. Training on the use of critical systems and processes that promote operational excellence in quality healthcare will be vital. Organizations, Practitioners and key support staff will promote excellence of quality and will be a focal point of the PPSs training strategy for the Workforce workstream.

3. IT Systems and Processes: Accurate Performance reporting will depend on the PPSs ability to validate and verify data provided by Organizations, Practitioners, Clinics and key support staff. There will be a critical dependency for a successful implementation of a performance

NYS Confidentiality – High
reporting culture and successful transformation of the PPSs IT Departments to ability customize existing systems, implement the new networks, and IT systems that will be utilized in performance reporting of patient outcome metrics. The project effectiveness and satisfaction will be evaluated in a continuous basis to ensure actual project benefits are being realized.

4. Governance, Finance, Clinical & Practitioner Engagement: It will be critical to Performance Reporting that all workstreams take a holistic 360 project approach and continuously evaluate the effectiveness the project, stakeholder management, project team involvement and whether the project will achieve established / identified goals. Clinical Integration and Practitioner Engagement are essential to the PPSs intent to create a common performance culture throughout the NCI PPS network, and to institute the new performance reporting practices within business, as a standard of excellence clinical practice.
IPQR Module 6.5 - Roles and Responsibilities

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Management Office and Project Management Officer</td>
<td>Ray Moore</td>
<td>Responsible for project management tracking and reporting for the 11 DSRIP projects, including their role in the performance reporting structures and processes in place across the PPS.</td>
</tr>
</tbody>
</table>
| Program Managers, Project Leads and specified entities (finance) | Overall Leads established, Per Partner Site /Project leadsTBD | Members of Project Teams
   Ultimately accountable for quality of patient care and financial outcomes per project
   Accountable for the realization and continuous improvement of the multi-disciplinary care pathways underlying their respective projects |
| Project Champions | NCI Board | Responsible for promoting a culture of continuous performance and improvement throughout the project. Responsible to ensure practitioners’ are involved in the performance monitoring processes and sustainment |
IPQR Module 6.6 - Key Stakeholders

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

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Applicant/Entity</td>
<td>North Country Initiative, LLC with Samaritan as signatory</td>
<td>Bylaw and Policy Development, funding and staff resources</td>
</tr>
</tbody>
</table>
| Safety Net Hospital partners              | Actively and accurately report on deliverables    | Active participation in governance and committee activities  
Meet timelines for deliverables and reporting of deliverables  
Participate in RCE to improve outcomes and deliverables where/when changes are needed |
| All PPS Partners                          | Actively and accurately report on deliverables    | Active participation in governance and committee activities  
Meet timelines for deliverables and reporting of deliverables  
Participate in RCE to improve outcomes and deliverables where/when changes are needed |
| **External Stakeholders**                 |                                                   |                                                                                                                                            |
| Fort Drum Regional Health Planning Organization | Workforce Vendor Assistance  
IT infrastructure  
Contracted PMO staffing and Support,  
Coordination of Activities | Training and Education  
IT Partnership  
Facilitation of Activities  
Continuity & Credibility                                                                 |
| Non-Partner Community Based Organizations | Engagement                                        | Understanding and buy-in                                                                                            |
| Medicaid and Uninsured Patients, All Population for Population Health Projects | Participation in neighborhood and community engagement activities | Information to ensure projects and activities are effective and appropriately targeted                                                   |
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.

North Country Initiatives ability to obtain information quickly on a patient's health, health care, and potential treatments is critically important. Additionally, the ability to share this information in a timely manner with other providers caring for the patient is essential to the delivery of safe, patient-centered, coordinated, and efficient health care. To meet this need, collaboration across the entire PPS is underway to develop and leverage: electronic health record (EHR) systems with decision support for clinicians, a secure platform for the exchange of patient information across health care settings, and data standards that will make shared information understandable to all users. Efforts are also underway to complete the implementation of a population health management tool that will allow our PPS to analyze, and aggregate real time data on our participants and those beneficiaries who opt in. NCI through the use of this tool will also be able to leverage information systems for mental health and substance abuse providers. Ensuring that the developing systems for mental health and substance abuse conditions are aligned with general, medical care needs is essential for improving the quality and continuity of care across the system. NCI's PPS will not be successful within DSRIP or any other Healthcare reform initiative if our information technology cannot produce reports on our ability to deliver safe, effective, patient-centered, timely health care. Those reports will be allow our PPS to take data and turn that information into healthcare decisions which will allow for improved patient outcomes and a reduction in healthcare cost.

All staff and participating providers will need to be trained on protecting health information through appropriate privacy and security practices. They will need to be trained on effective strategies to achieve ongoing, industrywide Health IT standards to include information tools, specialized network functions, and security protections for the interoperable exchange of health information. They will need to learn how to identify health IT standards for use by identifying and prioritizing specific uses for which health IT is valuable, beneficial and feasible. Overall, strong commitment from PPS to train, understand, and embrace the development of a shared, secure IT infrastructure will ultimately impact the successful use of IT functionality to improve outcomes.

It is vital to recognize the importance that our IT infrastructure has on our regions ability to reverse the cost curve and to improve the outcome of all the patients this region serves. Improvement in Information technology has been a commitment this region has made and will maintain throughout the regions transformation.

IPQR Module 6.8 - Progress Reporting

Instructions:

Please describe how you will measure the success of this organizational workstream.
North Country Initiative (NCI) has established a Project Management Office (PMO) staffed with a certified Project Management Officer and Program Manager.

The PMO will be utilizing (Performance Logic) a project management performance based software platform for monitoring, controlling and reporting (weekly, monthly, quarterly) status / metrics associated with project milestones / deliverables. Performance Logic is specifically designed to the needs of the PPS with project management, implementation, planning, performance monitoring and results oriented project tracking / reporting. Performance Logic incorporates all aspects of DSRIP tracking enhancing NCI's ability to communicate with multiple team members and essential stakeholders.

Delivering analytics and reports for state submission on milestones by DSRIP year (DY), financial incentives and DSRIP clinical measure domains including: (1) Patient Safety (2) Clinical Process/Effectiveness (3) Efficient Use of Healthcare Resources (4) Population/Public Health (5) Clinical Process/Effectiveness (6) Care Coordination (7) DSRIP Efficiency (8) Speed & Scale Utilization.

Reports and Metrics will be constructed using standard data definitions to facilitate timely, accurate, and clinically informed reporting that provides project oversight and feedback across organizational levels within the PPS. Data will be compiled and formulated to meet the intent of NYS reporting procedures and Achievement Values. Monthly and Quarterly: NCI PMO will evaluate and validate each performance and process measure and milestone on whether the target / milestone was “achieved” or “not achieved”. For targets / milestones that are “not achieved” further review will be conducted immediately to determine the root cause for “not achieved” and change management will be instituted if warranted to bring target / milestone to an “achieved” rating.

Domain 1: Project Milestones & Metrics are based largely on investments in technology, provider capacity and training, and human resources that will strengthen the ability of the PPS to serve its target populations and successfully meet DSRIP project goals. PPS project reporting will be conducted in two phases: A detailed Implementation Plan due in April 1, 2015 and ongoing Quarterly Reports throughout the entire DSRIP period. Both the initial Implementation Plan and Quarterly Reports shall demonstrate achievement towards the implementation of the IDS strategy and action plan, governance, completion of project requirements, scale of project implementation, and patient engagement progress in the project.

Quarterly Reports: PPS will submit quarterly reports on progress towards achievement of project requirements as defined in Domain 1 DSRIP Project Requirements Milestones & Metrics. Quarterly reports to the Independent Assessor will include project status and challenges as well as implementation progress. The format and content of the quarterly reports will be developed by the Independent Assessor and the Department of Health for the purpose of driving project payment upon completion of project milestones as indicated in the project application.

**IPQR Module 6.9 - IA Monitoring**

**Instructions:**
Section 07 – Practitioner Engagement

**IPQR Module 7.1 - Prescribed Milestones**

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

<table>
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<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
</table>
| Milestone #1        | 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 | 04/01/2015 | 12/31/2015 |         | DY1 Q3                           | NO |
| Task 1              | In Progress    | See Task                                                                                                                                                                                                   | 04/01/2015 | 09/30/2015 |         | DY1 Q2                           |    |
| Task 2              | In Progress    | See Task                                                                                                                                                                                                   | 04/01/2015 | 09/30/2015 |         | DY1 Q2                           |    |
| Task 3              | In Progress    | See Task                                                                                                                                                                                                   | 04/01/2015 | 12/31/2015 |         | DY1 Q3                           |    |
| Task 4              | In Progress    | See Task                                                                                                                                                                                                   | 04/01/2015 | 12/31/2015 |         | DY1 Q3                           |    |
### Milestone/Task Name

<table>
<thead>
<tr>
<th>Task</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
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<tbody>
<tr>
<td>1.</td>
<td>In Progress</td>
<td>Practitioner training / education plan.</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>NO</td>
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<td>2.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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</tr>
<tr>
<td>3.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<td>4.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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### Prescribed Milestones Narrative Text

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<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop Practitioners communication and engagement plan.</td>
<td></td>
</tr>
<tr>
<td>Develop training / education plan targeting practitioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.</td>
<td></td>
</tr>
</tbody>
</table>
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

✅ 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.

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

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**New York State Department Of Health**

**Delivery System Reform Incentive Payment Project**

**DSRIP Implementation Plan Project**

**Samaritan Medical Center (PPS ID:45)**

**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.

1. Risk: Geographic spread of PPS Region for Clinical Champions
   Mitigation: NCI Board and Committees includes Providers champions from across the PPS geographic region
2. Risk: Geographic spread for training
   Mitigation: Training offered at Medical staff and other group settings. In addition a Webinar will be developed that can be utilized and accessed in a lunch and learn format
3. Risk: Change resistance
   Mitigation: Diversified Clinical peer leaders, evidence-based changes, regular performance reports, incentives

**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.)

1. Performance Reporting and Clinical Integration: NCI communication plans for practitioner engagement depend on effective, rapid communication process and regular two-way communication channels including for performance reporting and clinical integration. If clinical outcomes are to be met, communication of clinical activities through practitioner engagement must be utilized to address poor performing areas
2. Governance: The role of the Practitioner Champions is central to NCI plans for practitioner engagement. NCI Clinical Champions actively participate in the governance structure including the Executive Body on behalf of the practitioners and will be responsible for communicating information to those practitioners groups effectively. NCI practitioner engagement is dependent on an effective governance structure and processes.
3. Financial Sustainability, Budget and Funds Flow: Practitioner engagement in the finance committees and the funds flow for performance and value based payment are the keys to changing the healthcare delivery system into a outcome focused system.
4. Workforce: Practitioners are a significant component of the healthcare workforce therefore the training of practitioners is directly linked to the workforce workstream.
5. IT Systems and Processes: EMR, PHM (disease registry), and HIE Technology provides the efficient means standardize measure and improve PH outcomes and the information to inform performance reporting for practitioner engagement.
**IPQR Module 7.5 - Roles and Responsibilities**

**Instructions:**

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
</table>
| NCI Board                     | Board Chair, Dr. Collins Kellogg  
Board Members                                                                                                              | Inclusion of Providers in Governance and Committee Structure                                        |
| NCI Medical Management (Clinical) Committee | Chair, Dr. Steven Lyndaker  
Members                                                                                                                             | Review training webinar and materials                                                               |
| NCI Program Manager           | Celia Cook                                                                                                               | Development of Communication Plan  
Assistance in webinar and other communication material development                                      |
| NCI Project Management Officer | Ray Moore                                                                                                                | Development of standard performance reports                                                         |
| NCI Data Analyst              | Jeff Bazinet                                                                                                             | Ensure disease registry capability for quality performance reporting for inclusion in standard reports |
| NCI Board Provider Champions  | Dr. Collins Kellogg  
Dr. Gary Hart  
Dr. Steven Lyndaker  
Dr. David Rechlin  
Dr. Mario Victoria  
Dr. Mark Parshall  
Dr. Michael Seidman  
Dr. Michael Woznicki  
Dr. Howard Meny  
Dr. Jack Rush  
Dr. Jason White  
Erin Cooney, LCSW-R  
Jeff Perrine, FNP  
Angela Doe, LMHC | Facilitate education of medical staffs and other provider groups on clinical integration                                      |
| NCI Director Regional CIO Workforce Lead | Brian Marcolini  
Corey Zeigler  
Tracy Leonard                                                                                                                | Facilitate development of webinar and other education materials                                     |
**IPQR Module 7.6 - Key Stakeholders**

Instructions:

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

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCI Board</td>
<td>Board Members</td>
<td>Review and Accept Practitioner Communication and Training Plan</td>
</tr>
<tr>
<td>NCI Communication Committee</td>
<td>Include Practitioner Engagement in two-way Communication Plan</td>
<td>Communication Plan that addresses Practitioner Engagement</td>
</tr>
<tr>
<td>NCI Director</td>
<td>Responsible for overall oversight of all NCI Activities</td>
<td>Ensure that all workstreams endorse and adopt plans as applicable</td>
</tr>
<tr>
<td>NCI Care Management Committee</td>
<td>Inform training/education for practitioners regarding Care Management Plan</td>
<td>Care Management Plan included in training</td>
</tr>
<tr>
<td>Safety Net hospital partners</td>
<td>Adopt and participate in plans and training as applicable</td>
<td>Trained medical professional staff, implemented plans to impact improved practitioner engagement</td>
</tr>
<tr>
<td>All PPS Partners</td>
<td>Adopt and participate in plans and training as applicable</td>
<td>Trained medical professional staff, implemented plans to impact improved practitioner engagement</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Drum Regional Health Planning Organization</td>
<td>Contracted PMO staffing and Support, Coordination of Activities Community Based Engagement</td>
<td>Facilitation of Activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Analytics for performance report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continuity &amp; Credibility for Community Provider Practitioner Engagement</td>
</tr>
<tr>
<td>Non-Partner Community Based Organizations</td>
<td>Engagement Potential to provide service</td>
<td>Understanding and buy-in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability to facilitate larger community understanding</td>
</tr>
<tr>
<td>Medicaid and Uninsured Patients, All Population for Population Health Projects</td>
<td>Trained, engaged providers support better outcomes for patients</td>
<td>Feedback on provider through CAHPS</td>
</tr>
</tbody>
</table>
IPQR Module 7.7 - IT Expectations

Instructions:

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

Health Information Technology or HIT platforms to support communication between practitioners will be critical for engaging practitioners in DSRIP and for the sharing of best practices. We are developing a PHM platform to support the NCI PPS to provide progress reporting and feedback on measures and chosen protocols.

The ability for providers to share clinical information easily is important, not just for improvements in clinical processes and outcomes but also for the ongoing buy-in of individual practitioners. It is critical that the IT infrastructure developed be integrated into practitioner workflow and is seen as a tool to improve care, not another non-value-add task they need to complete.

Improved IT infrastructure will also be important for the delivery of our practitioner engagement education and training materials. We are integrating telemedicine tools (video conferencing) and other collaborative tools to assist providers in sharing their knowledge, best practices and enhancing the learning environment across the PPS and beyond.

IPQR Module 7.8 - Progress Reporting

Instructions:

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

NCI will monitor Practitioner Engagement through NCI governance inclusion, board and committee meeting attendance, communication plan development and communication plan activities compleeteion, the trainings/presentations/education developed and conducted for providers groups and the delivery of aggregate provider group reporting.

These activities will be monitored by the PMO utilizing (Performance Logic) a project management performance based software platform for monitoring, controlling and reporting (weekly, monthly, quarterly) status / metrics associated with project milestones / deliverables. Performance Logic is specifically designed to the needs of the PPS with project management, implementation, planning, performance monitoring and results oriented project tracking / reporting. Performance Logic incorporates all aspects of DSRIP tracking enhancing NCI's ability to communicate with multiple team members and essential stakeholders.

IPQR Module 7.9 - IA Monitoring
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

Instructions:
Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

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

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
</table>
| Milestone #1        | 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. | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | NO |
<p>| Task 8. PPS PCMH Certification Team to finalize PPS-wide plan for achieving Level 3 certification for relevant providers | In Progress | See Task | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| Task 8a. Plan will include assessments of all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH | In Progress | See Task | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| Task 8b. Plan will include a gap analysis on the results to determine the scope of work/needed assistance for each PCP | In Progress | See Task | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| Task 8c. Plan will include project plan/timeline for each PCP | In Progress | See Task | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4 | |
| Task 8d. Plan will include the PCMH processes, procedures, protocols and written policies. | In Progress | See Task | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |
| Task 8e. Plan will include timeline for NCQA Level | In Progress | See Task | 04/01/2015 | 06/30/2016 | 06/30/2016 | DY2 Q1 | |</p>
<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 PCMH submissions</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 8. Plan will include all practices to meet NCQA 2014 Level 3 PCMH and/or APCM standards.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 9. Clinical Quality Committee to finalize population health management roadmap for Board approval</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 1. Conduct inventory of available data sets with individual demographic, health, and community status information, to supplement use of the data available through the MAPP tool</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 2. Working with Population Health Improvement Program, identify key aggregate population health datasets for annual CNA update and determine process for annual update</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 3. Evaluate IT capacity and identify gaps in IT infrastructure at a provider level as applicable to projects that need to be addressed to support access to disease registry capability to impact Domain 3 quality metrics as defined for NCI Projects</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 4. Ensure workforce assessment includes priority practice groups' care management capabilities, including staff skills and resources required to manage the diabetic and cardiovascular disease populations in each geographic area</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 5. Establish NCI PPS PCMH Certification Team responsible for assessing current state with regard to PCMH 2014 Level 3 certification, identifying key gaps and developing</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
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<tr>
<td>Milestone/Task Name</td>
<td>Status</td>
<td>Description</td>
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<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
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</tr>
<tr>
<td>overarching plan to achieve Level 3 certification in all relevant providers</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>NO</td>
</tr>
<tr>
<td>Task 6. Ensure care guidelines for providers are developed for priority clinical issues as required for PPS projects with clinical metrics to monitor progress in managing population health</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 7. Reference and incorporate health literacy and cultural competency strategy for targeting and addressing health disparities</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
<td>NO</td>
</tr>
<tr>
<td>Milestone #2 Finalize PPS-wide bed reduction plan.</td>
<td>In Progress</td>
<td>PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 1. Perform a gap analysis to accurately determine current inpatient bed capacity/bed constraints across the PPS (determine optimal inpatient delivery model)</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 2. Establish Service Utilization Monitoring Team made up of an assigned lead from each impacted hospital to provide oversight in measuring, evaluating, and recommending excess bed reductions to NCI Governing Board. (determine the number beds that can be reduced vs. percent of staffed beds.)</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 3. Each participating hospital facility will develop a strategic plan that outlines: medical village services, inpatient capacity transition plan, stakeholder engagement processes, capital improvement requirements, geographical location of medical village, marketing and consumer education and community involvement.</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td></td>
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</tbody>
</table>
### Milestone/Task Name

- **Task 4.** The NCI PPS collaboratively compiles a strategic plan that outlines: medical village services, inpatient capacity transition plan, stakeholder engagement processes, capital improvement requirements, geographical locations of medical villages, marketing and consumer education and community involvement.

  **Status:** In Progress  
  **Description:** See Task  
  **Start Date:** 04/01/2015  
  **End Date:** 09/30/2016  
  **Quarter End Date:** 09/30/2016  
  **DSRIP Reporting Year and Quarter:** DY2 Q2

- **Task 5.** Each plan will detail community involvement: requirements/roles and responsibilities that will be completed during the project lifecycle

  **Status:** In Progress  
  **Description:** See Task  
  **Start Date:** 04/01/2015  
  **End Date:** 09/30/2016  
  **Quarter End Date:** 09/30/2016  
  **DSRIP Reporting Year and Quarter:** DY2 Q2

- **Task 6.** Approval of Individual Strategic Plans by individual hospital boards.

  **Status:** In Progress  
  **Description:** See Task  
  **Start Date:** 04/01/2015  
  **End Date:** 09/30/2016  
  **Quarter End Date:** 09/30/2016  
  **DSRIP Reporting Year and Quarter:** DY2 Q2

- **Task 7.** Approval of Individual Strategic Plans by NCI Governing Board

  **Status:** In Progress  
  **Description:** See Task  
  **Start Date:** 04/01/2015  
  **End Date:** 12/31/2016  
  **Quarter End Date:** 12/31/2016  
  **DSRIP Reporting Year and Quarter:** DY2 Q3

- **Task 8.** Approval of NCI PPS collaborative Medical Village strategic Plan by NCI Governing Board.

  **Status:** In Progress  
  **Description:** See Task  
  **Start Date:** 04/01/2015  
  **End Date:** 12/31/2016  
  **Quarter End Date:** 12/31/2016  
  **DSRIP Reporting Year and Quarter:** DY2 Q3

### Prescribed Milestones Current File Uploads

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### Prescribed Milestones Narrative Text

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<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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</thead>
<tbody>
<tr>
<td>Develop population health management roadmap.</td>
<td></td>
</tr>
<tr>
<td>Finalize PPS-wide bed reduction plan.</td>
<td></td>
</tr>
</tbody>
</table>
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

☑ 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.

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

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### PPS Defined Milestones Narrative Text

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

No Records Found
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.

1. Population Health Risk: Provider engagement/burnout
   Mitigation: Provide external support to assist practices. Develop by practice project plan to include all PCP DSRIP clinical guidelines, workflow changes and training directly into PCMH implementation (measure twice-cut once approach)

2. Population Health Risk: Providers not reporting discreetly in EMRs to allow clinical measures to be mapped to disease registry for reporting and tracking purposes.
   Mitigation: Engage data analysts for data quality analysis of every PHM interface by provider to determine if measure correctly mapped, if software can provide data discreetly and then develop per provider plan to improve discreet data element entry to EMR

3. Population Health Risk: PHM vendor inability to meet aggressive DSRIP schedule to deliver by provider reporting to inform incentive plan development. It is so easy to put disease registry capability on par and a completely different matter to effectively map and launch from multiple disparate EMRs
   Mitigation: Service Level Agreements built into PHM contracts. Understanding and agreement of support level needed by both the PPS and vendor prior to implementation.

4. Bed Reduction Risk: Impact is higher or lower than anticipated during planning phase
   Mitigation: Regular ongoing monitoring prepared for RCE

5. Bed Reduction Risk: Increased insurance utilization and patient activation through PAM, initially increases instead of decreases bed utilization
   Mitigation: Performance monitoring identification of trends to inform planning on regular basis

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.)

1. Governance: NCI Governance will need to oversee development of incentive plan to drive improved population health outcomes.
2. Financial Sustainability: The Bed Reduction plan is tied directly to the impact analysis and other financial activities being undertaken under the financial sustainability work stream. NCI Finance Committee will need to monitor financial impact assessment and ongoing metrics.
3. Budget and Funds Flow: Budget and funds flow are closely tied to both population health activities and bed reduction/revenue losses
4. Workforce: Support at provider level (as part of practitioner engagement training plan) to train providers to use and apply information learned from the registry; how to implement established care guidelines developed as part of project implementations will cross into workforce training sector
5. Practitioner Engagement, Clinical Projects, Clinical Integration and Care Coordination: If Population Health clinical outcomes are to be met all
clinical activities must align and be prepared to address poor performing areas

6. IT Systems and Processes: EMR, PHM, and HIE Technology provides the only efficient means standardize measure and improve PH outcomes.
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

✅ IPQR Module 8.5 - Roles and Responsibilities

Instructions:

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCI Data Analyst</td>
<td>Jeff Bazinet</td>
<td>Inventory available data sets and PHM disease registry capacity</td>
</tr>
<tr>
<td>FDRHPO PHIP Program Manager</td>
<td>Ian Grant</td>
<td>Engage regional Population Health Improvement Program</td>
</tr>
<tr>
<td>Regional Chief Information Officer</td>
<td>Corey Zeigler</td>
<td>Evaluate IT capacity, identify gaps, develop plan</td>
</tr>
<tr>
<td>Senior Nurse Informaticist</td>
<td>Liza Darou</td>
<td>Establish NCI PPS PCMH Certification Team</td>
</tr>
<tr>
<td>NCI Medical Management (clinical) Committee</td>
<td>Committee Members</td>
<td>Ensure care guidelines are developed</td>
</tr>
<tr>
<td>Workforce Lead &amp; Workforce Vendors</td>
<td>Tracy Leonard, Greg Dewitt</td>
<td>Ensure workforce assessment includes practice skills/resources</td>
</tr>
<tr>
<td>NCI Health Literacy &amp; Cultural Competency Committee</td>
<td>Committee Members</td>
<td>Ensure target population for health disparities are identified</td>
</tr>
<tr>
<td>NCI Safety Net Hospital Partners</td>
<td>Samaritan Medical, Claxton Hepburn, Carthage Area, River Hospital, Massena Memorial, Clifton Fine</td>
<td>Assign staff to service utilization monitoring team</td>
</tr>
<tr>
<td>Service Utilization Monitoring Team</td>
<td>TB Assigned</td>
<td>Monitor and report bed utilization and reduction metrics</td>
</tr>
</tbody>
</table>
### Key Stakeholders

**Instructions:**

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

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
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<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCI Board of Managers</td>
<td>Board Members</td>
<td>Review and accept plans</td>
</tr>
<tr>
<td>NCI Communication Committee</td>
<td>Include PH in Communication Plan</td>
<td>Communication Plan that addresses PH</td>
</tr>
<tr>
<td>NCI Director</td>
<td>Responsible for overall oversight of all NCI Activities</td>
<td>Ensure that all work streams endorse and adopt plans as applicable</td>
</tr>
<tr>
<td>NCI Care Management Committee</td>
<td>Include PH as Base component for Care Management Plan</td>
<td>Care Management Plan addresses Population Health</td>
</tr>
<tr>
<td>Safety Net hospital partners</td>
<td>Adopt and participate in plans and training as applicable</td>
<td>Trained staff, implemented plans to impact improved population health and achievement of bed reductions</td>
</tr>
<tr>
<td>All PPS Partners</td>
<td>Adopt and participate in plans and training as applicable</td>
<td>Trained staff, implemented plans to impact improved population health</td>
</tr>
<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Drum Regional Health Planning Organization</td>
<td>Contracted PMO staffing and Support, Coordination of Activate Community Based Engagement</td>
<td>Facilitation of Activities Data Analytics to identify Continuity &amp; Credibility for Community Engagement with Population Health Improvement Program and other Community Based programs</td>
</tr>
<tr>
<td>Non-Partner Community Based Organizations</td>
<td>Engagement Potential to provide service</td>
<td>Understanding and buy-in</td>
</tr>
<tr>
<td>Medicaid and Uninsured Patients, All Population for Population Health Projects</td>
<td>Participation in neighborhood and community engagement activities</td>
<td>Information to ensure projects and activities are effective and appropriately targeted</td>
</tr>
</tbody>
</table>
IPQR Module 8.7 - IT Expectations

Instructions:

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

One of the key principles of our approach to population health management is that all care will become 'data-driven'. Our data & analytics team will be responsible for ensuring that practitioners have the data and the tools available to allow them to develop interventions and services that will address the wider determinants of population health for their local population. This effort will be facilitated by the use of a regional PHM solution and also plan to utilize the MAPP PPS-specific Performance Measurement Portal, which will help our team monitor performance of both claims-based, non-hospital CAHPS DSRIP metrics AND DSRIP population health metrics. The analysis of population-level outcome data will also be the basis for our assessment of the impact of population health management on the priority groups and clinical areas.

Our PPS is fully partnered with HealtheConnections (HeC), our RHIO, and leadership will require all partners to connect with HeC to service our attributed population. This effort will be conducted in tandem with the EHR platforms, care management, and population health management systems that we have already implemented, or are currently implementing.

IPQR Module 8.8 - Progress Reporting

Instructions:

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

The NCI will utilize a disease registry to monitor and manage population health from a clinical perspective. These clinical metrics along with all organizational measures and metrics will be monitored and reported by the NCI PMO as outlined below.

The North Country Initiative (NCI) has established a Project Management Office (PMO) staffed with a certified Project Management Officer and Program Manager. The PMO will be utilizing (Performance Logic) a project management performance based software platform for monitoring, controlling and reporting (weekly, monthly, quarterly) status / metrics associated with project milestones / deliverables. Performance Logic is specifically designed to the needs of the PPS with project management, implementation, planning, performance monitoring and results oriented project tracking / reporting. Performance Logic incorporates all aspects of DSRIP tracking enhancing NCI's ability to communicate with multiple team members and essential stakeholders.

IPQR Module 8.9 - IA Monitoring

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

Samaritan Medical Center (PPS ID:45)
Section 09 – Clinical Integration

### IPQR Module 9.1 - Prescribed Milestones

Instructions:

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

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

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td>In Progress</td>
<td>Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td>NO</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
</tbody>
</table>
### Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 1. Utilizing needs assessment, develop clinical integration strategy incorporated into project plans</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 2. Ensure strategy includes the four pillars: provider leadership, aligned incentives; clinical and care management/ transition strategy; technology/ data infrastructure to support integration</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 3. Include training for operational staff on care coordination and communication tools (this is also included in project implementation plans - it is not expected that training will be duplicative but that training meeting deliverables will be reflected in multiple applicable places in quarterly reports)</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Task 4. Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee</td>
<td>In Progress</td>
<td>See Task</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
<td></td>
</tr>
<tr>
<td>Milestone #2 Develop a Clinical Integration strategy.</td>
<td>In Progress</td>
<td>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</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>NO</td>
</tr>
</tbody>
</table>
**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**  

**Samaritan Medical Center (PPS ID:45)**

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
<th>AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Clinical Integration Strategy, signed off by Clinical Quality Committee</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
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</table>

**Prescribed Milestones Current File Uploads**

<table>
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<tr>
<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
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</thead>
<tbody>
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**Prescribed Milestones Narrative Text**

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform a clinical integration 'needs assessment'.</td>
<td></td>
</tr>
<tr>
<td>Develop a Clinical Integration strategy.</td>
<td></td>
</tr>
</tbody>
</table>
### IPQR Module 9.2 - PPS Defined Milestones

Instructions:

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

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

No Records Found

### PPS Defined Milestones Current File Uploads

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

No Records Found

### PPS Defined Milestones Narrative Text

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

No Records Found
IPQR Module 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.

1. Risk: Geographic spread of Clinical Champion representation
   Mitigation: NCI Board and Committees includes Providers champions from across the PPS geographic region
2. Risk: Geographic spread for training
   Mitigation: Training offered at Medical staff and other group settings. In addition a Webinar will be developed that can be utilized and accessed in a lunch and learn format
3. Risk: Change resistance
   Mitigation: Peer leaders, evidence-based changes, regular performance reports, office champions, incentives
4. Risk: Data gathering and interfaces with Disease registry
   Mitigation: Data quality surveillance team deployed and other integration options being utilized like HIE.

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.)

Clinical Integration is what DSRIP is attempting to achieve to improve care and reduce costs for the Medicaid population served. The four pillars of clinical integration are encompassing of all the DSRIP work streams. In particular:
1. Performance Reporting and Communication: NCI communication plans for practitioner engagement and clinical integration depends on effective, rapid communication process and regular two-way communication channels including performance reporting and clinical integration.
2. IT Systems and Processes: Without IT Systems it is impossible to have the effective clinical performance monitoring processes that are the bedrock of CI.
3. Governance: The role of the Practitioner Champions is central to NCI plans for clinical integration. NCI Clinical Champions must be empowered to actively participate in the governance structure including the Executive Body on behalf of the practitioners and communicating information back down to those practitioners effectively. The NCI clinical integration strategy is dependent on an effective governance structure and processes.
## IPQR Module 9.5 - Roles and Responsibilities

**Instructions:**

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCI Board</td>
<td>Board Chair, Dr. Collins Kellogg&lt;br&gt;Board Members&lt;br&gt;Dr. Gary Hart&lt;br&gt;Dr. Steven Lyndaker&lt;br&gt;Dr. David Rechlin&lt;br&gt;Dr. Mario Victoria&lt;br&gt;Dr. Mark Parshall&lt;br&gt;Dr. Michael Seidman&lt;br&gt;Dr. Howard Meny&lt;br&gt;Dr. Jack Rush&lt;br&gt;Dr. Jason White&lt;br&gt;Erin Cooney, LCSW-R&lt;br&gt;Jeff Perrine, FNP&lt;br&gt;Angela Doe, LMHC</td>
<td>Inclusion of Providers in Governance and Committee Structure&lt;br&gt;Review training webinar and material, ensure proper selection and implementation of evidence based guidelines and protocols&lt;br&gt;Development of Communication Plan&lt;br&gt;Assistance in webinar and other communication material development&lt;br&gt;Facilitate education of medical staffs and other provider groups on clinical integration</td>
</tr>
<tr>
<td>NCI Medical Management (Clinical) Committee</td>
<td>Chair, Dr. Steven Lyndaker&lt;br&gt;Members&lt;br&gt;Celia Cook</td>
<td>Development of standard performance reports&lt;br&gt;Facilitate development of webinar and other education materials</td>
</tr>
<tr>
<td>NCI Program Manager</td>
<td>Celia Cook</td>
<td>Assistance in webinar and other communication material development</td>
</tr>
<tr>
<td>NCI Project Management Officer</td>
<td>Ray Moore</td>
<td>Development of standard performance reports</td>
</tr>
<tr>
<td>NCI Data Analyst</td>
<td>Jeff Bazinet</td>
<td>Ensure disease registry capability for quality performance reporting for inclusion in standard reports</td>
</tr>
<tr>
<td>NCI Board Provider Champions</td>
<td>Brian Marcolini&lt;br&gt;Corey Zeigler&lt;br&gt;Tracy Leonard</td>
<td>Facilitate development of webinar and other education materials</td>
</tr>
<tr>
<td>NCI Director</td>
<td>Brian Marcolini&lt;br&gt;Corey Zeigler&lt;br&gt;Tracy Leonard</td>
<td>Facilitate development of webinar and other education materials</td>
</tr>
<tr>
<td>Regional CIO</td>
<td>Brian Marcolini&lt;br&gt;Corey Zeigler&lt;br&gt;Tracy Leonard</td>
<td>Facilitate development of webinar and other education materials</td>
</tr>
<tr>
<td>Workforce Lead</td>
<td>Brian Marcolini&lt;br&gt;Corey Zeigler&lt;br&gt;Tracy Leonard</td>
<td>Facilitate development of webinar and other education materials</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
IPQR Module 9.6 - Key Stakeholders

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

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCI Board</td>
<td>Board Members</td>
<td>Review and Accept Practitioner Communication and Training Plan</td>
</tr>
<tr>
<td>NCI Communication Committee</td>
<td>Include Practitioner Engagement in two-way Communication Plan</td>
<td>Communication Plan that addresses Practitioner Engagement</td>
</tr>
<tr>
<td>NCI Director</td>
<td>Responsible for overall oversight of all NCI Activities</td>
<td>Ensure that all work streams endorse and adopt plans as applicable</td>
</tr>
<tr>
<td>NCI Care Management Committee</td>
<td>Inform training/education for practitioners regarding Care Management Plan</td>
<td>Care Management Plan included in training</td>
</tr>
<tr>
<td>Safety Net hospital partners</td>
<td>Adopt and participate in plans and training as applicable</td>
<td>Trained medical professional staff, implemented plans to impact improved practitioner engagement</td>
</tr>
<tr>
<td>All PPS Partners</td>
<td>Adopt and participate in plans and training as applicable</td>
<td>Trained medical professional staff, implemented plans to impact improved practitioner engagement</td>
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<tr>
<td><strong>External Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Drum Regional Health Planning Organization</td>
<td>Contracted PMO staffing and Support, Coordination of Activate Community Based Engagement</td>
<td>Facilitation of Activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Data Analytics for performance report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Continuity &amp; Credibility for Community Provider Practitioner Engagement</td>
</tr>
<tr>
<td>Non-Partner Community Based Organizations</td>
<td>Engagement</td>
<td>Understanding and buy-in</td>
</tr>
<tr>
<td></td>
<td>Potential to provide service</td>
<td>Ability to facilitate larger community understanding</td>
</tr>
<tr>
<td>Medicaid and Uninsured Patients, All Population for Population Health Projects</td>
<td>Trained, engaged providers support better outcomes for patients</td>
<td>Feedback on provider through CAHPS</td>
</tr>
</tbody>
</table>
**IPQR Module 9.7 - IT Expectations**

**Instructions:**

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

Effective clinical integration will require relevant information to be readily accessible for providers across the patient care spectrum. For the providers, this will mean integration into new or expanded clinical data systems, such as population health management disease registry capability, which NCI will roll out across the primary care provider network. A core element of NCI's clinical integration needs assessment will be identifying where new or expanded data-sharing systems are required or where a different approach is required. At this stage, the immediate priorities (quick wins) include: medication reconciliation, patient transfers and transport, and outpatient clinic scheduling.

Achieving the buy-in of NCI's large community of downstream providers to the new work flows that fall under the clinical integration work stream will greatly depend on the providers and the individual practitioners having easily accessible methods of communicating with one another. We have secure messaging, weekly communication updates and other collaboration tools to ensure providers are aware of the project(s) and have a method to drive the success through their engaged guidance.

---

**IPQR Module 9.8 - Progress Reporting**

**Instructions:**

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

NCI will use the four pillars of Clinical Integration to monitor and evaluate our networks success. First, NCI will review, evaluate and confirm performance of our network to the standards and measures of DSRIP, specific disease programs, care protocols and clinical metrics utilizing disease registry capability. These will be tracked to ensure NCIs ability to meet the 4 pillars of clinical integration and to ensure incentives are paid out that are aligned with positive patient outcomes.

Secondly, NCI will monitor progress of PPS providers connected to the Health Information Exchange, Disease Registry and those utilizing Patient Portals and secure messaging for Domain 1 metrics through the PMO and performance logic software. Third, NCI will measure success through surveying providers to gain feedback on the effectiveness of clinical integration and care coordination within our region. Finally NCI understands that proper clinical integration within the DSRIP program will reduce hospitalizations (PQI’s) and potentially preventable visits. NCI will have a coordinated plan that will monitor and assess our progress towards those milestones.

The North Country Initiative (NCI) has established a Project Management Office (PMO) staffed with a certified Project Management Officer and Program Manager. The PMO will be utilizing (Performance Logic) a project management performance based software platform for monitoring, controlling and reporting (weekly, monthly, quarterly) status / metrics associated with project milestones / deliverables. Performance Logic is specifically designed to the needs of the PPS with project management, implementation, planning, performance monitoring and results oriented project tracking / reporting. Performance Logic incorporates all aspects of DSRIP tracking enhancing NCI's ability to communicate with multiple stakeholders.
team members and essential stakeholders.

**IPQR Module 9.9 - IA Monitoring:**

**Instructions:**
Section 10 – General Project Reporting

✅ IPQR Module 10.1 - Overall approach to implementation

Instructions:

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

The overall approach that the NCI PPS is taking towards the implementation of its 11 DSRIP projects is based on delegated governance, clinical leadership, meaningful communication, transparency, interoperable HIT, standardization of protocols, and aligned incentives with change management as the critical factor.

NCl fully understands the difficulty of what is being undertaken through DSRIP. This is a culture shift that flips the healthcare business model. The only way to successfully and sustainably achieve this shift is to approach it from a change management lens. The NCI implementation team has identified the 10 top keys to NCI's success to be applied to all projects:

1. Change management: Every single DSRIP project and workflow requires change management. Managing this type of change requires a shared NCI organizational culture that conveys a sense of identity for NCI partners, facilitates commitment to something larger than self-interest, enhances stability of the system while remaining flexible to change in response to new demands or strategies and serves as a mechanism for decision-making. The NCI will act as an integrated delivery system, adopting system-wide workflows, contracting for system-wide services, and implementing projects systematically across partners.

2. Proceed as if success is inevitable: We will proceed as if success is inevitable. And then make sure it is, by utilizing detailed tracking of milestones and metrics to ensure outcomes are being met and RCE course corrections are made.

3. Trust each other: NCI cannot and will not know all of the answers, this is new territory. We have to trust each other to watch each other's backs and look ahead for hazards. A strong delegated inclusive governance structure will put in place the processes for trust and decision-making.

4. We have the power to engage patients: NCI must identify the patients' needs and align our priorities with those needs. Patient engagement crosses all projects. Two-way patient engagement strategies will contribute to the success of all projects.

5. Confidence: We and only we, know how to do this for the population we serve. We will maintain confidence that together we either know or can find the answers we need to be successful. Sharing and adoption of best practices across projects is critical to success.

6. Accurate data and analysis of that data: Accurate data will be needed to drive all projects and lead to NCI's future success. That means EMR data going in must be clean, it must be mapped to disease registry accurately and it must be presented in manner that allows it to be used to drive decisions. Thus confidence, see 5.

7. Increased primary care access: We cannot succeed unless we expand primary care access in multiple ways. More providers, extended hours, new locations and ensuring physicians practice at the top of their licensure.

8. Value community based partners: Hospitals and physicians cannot do this alone. Community based providers must be active and engaged across all projects and involved in governance. They are catalysts and keys to DSRIP success.

9. Design for behavior change: When the system, beliefs or knowledge that creates a behavior changes, the behavior changes. This is true for providers, patients and communities. We need to identify design means to make the needed change easy for project success.

10. Understand the shared bucket: Transparency of funds flow is critical so that all understand the shared bucket and the expectations for their share. Effort equals reward based on project. In addition, understanding that our MCOs also have a shared bucket and how we can contribute to their success will be critical to VBP in the future.

By approaching the Project Implementations in a cohesive manner the NCI has the most potential to achieve all DSRIP outcomes and to be
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

prepared to sustain DSRIP created change into the future.

☑️ 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 NCI's approach to handling the major independencies between projects and workstreams is to handle these interdependencies as an integrated delivery system rather in separate partner silos. This approach will ensure that partners will not be working towards similar goals or project requirements independently, thereby doubling effort and potentially creating multiple approaches to solving the same issue. This integrated delivery system approach includes contracting for services in a centralized manner, centralization project leads, identification of clinical workflows and governance.

1. The NCI will contract for services in a centralized manner for all PPS partners with similar needs. This includes:
   a. EMR, HIE, PCMH and PHM implementation support. In this manner as the EMR is implement, PCMH workflows are included along with the clinical workflows for the projects under the guidelines identified by the Med Management Committee.
   
   In addition this ensures that rollout across the PPS is coordinated via a single staggered implementation plan allowing for maximum economy of scale and resources with maximum impact on project success.
   
   b. Services not currently covered like Diabetes Prevention Programs, Tobacco Cessation Programs, Diabetes and Psychiatry support for practices via telemedicine and care transitions/care management.
   
   c. Training and education such as PAM, Community Health Worker, Care Management Training, Health Literacy and Cultural Competency. In this manner all PPS staff will have the same training and same understanding creating a truly integrated knowledge set and operational culture.
   
2. The NCI will have a centralized Project Lead for each Major workstream who will coordinate all activities within that workstream between partners. These major cross cutting workstreams are: Care Coordination/Transitions, Workforce, IT Systems and Processes, Communication Planning, Community Engagement, Finance and Contracting and Population Health.

3. The NCI Medical Management Committee is identifying clinical workflow overlap and developing EMR specific toolkits for practices to streamline processes for value add. Clinical Leadership and clinical champions will be key to successful DSRIP implementations and outcomes.

4. The NCI has or will establish governance structures for all major workstreams that cut across multi sectors that require governance decisions. This includes clinical governance, HIT governance, data governance, workforce governance, compliance governance, and financial governance.

NYS Confidentiality – High
**IPQR Module 10.3 - Project Roles and Responsibilities**

**Instructions:**

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Lead Applicant</td>
<td>Samaritan Medical Center</td>
<td>Compliance Officer and Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fiduciary Lead - funds distribution based on NCI Finance Committee and Board Governance Recommendations</td>
</tr>
<tr>
<td>NCI Board Chairman</td>
<td>Board Chair, Dr. Collins Kellogg</td>
<td>Facilitate Board of Manager Activities, Lead Board spokesperson &amp; Clinical Champion</td>
</tr>
<tr>
<td>NCI Medical Director</td>
<td>Dr. Steven Lyndaker</td>
<td>Review training webinars and material</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ensure selection and implementation of evidence based guidelines and protocols</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop and assist practice workflow strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical quality measures</td>
</tr>
<tr>
<td>NCI Board Provider Champions</td>
<td>Dr. Collins Kellogg, Dr. Gary Hart, Dr. Steven Lyndaker, Dr. David Rechlin, Dr. Mario Victoria, Dr. Mark Parshall, Dr. Michael Seidman, Dr. Michael Woznicki, Dr. Howard Meny, Dr. Jack Rush, Dr. Jason White, Erin Cooney, LCSW-R, Jeff Perrine, FNP, Angela Doe, LMHC</td>
<td>Physician/Provider Champions and leadership Facilitate education of medical staffs and other provider groups on clinical integration</td>
</tr>
<tr>
<td>NCI Director</td>
<td>Brian Marcolini</td>
<td>Overall NCI Leadership. Coordinate overall development of VBP baseline assessment and plan for achieving value based payments. Coordinate approach and engagement of process to develop PPS VBP Baseline Assessment and Adoption Plan. Ultimately responsible for the development of the PPS VBP Baseline Assessment and Adoption Plan.</td>
</tr>
<tr>
<td>NCI Program Manager</td>
<td>Celia Cook</td>
<td>Documentation and facilitation of Communication and Community</td>
</tr>
<tr>
<td>Role</td>
<td>Name of person / organization (if known at this stage)</td>
<td>Key deliverables / responsibilities</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>NCI Project Management Officer</td>
<td>Ray Moore</td>
<td>Development of standard performance reports Development of site project leads</td>
</tr>
<tr>
<td>NCI Data Analyst</td>
<td>Jeff Bazinet</td>
<td>Ensure disease registry capability for quality performance reporting for inclusion in standard reports</td>
</tr>
<tr>
<td>NCI Director</td>
<td>Brian Marcolini</td>
<td>Facilitate development of webinar and other education materials</td>
</tr>
<tr>
<td>Regional CIO Workforce Lead</td>
<td>Brian Marcolini, Corey Zeigler, Tracy Leonard</td>
<td>Oversee development of webinar and other communication material</td>
</tr>
<tr>
<td>NCI Finance/Contracting Director</td>
<td>Unknown at this time. Responsibilities will be fulfilled by Lead Entity CFO and NCI Director until determined.</td>
<td>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 compliance role will report to the Executive Body.</td>
</tr>
<tr>
<td>NCI DSRIP Compliance Officer</td>
<td>TBD will be filled by the Lead Entity Compliance Officer in the interim</td>
<td>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 compliance role will report to the Executive Body.</td>
</tr>
<tr>
<td>Lead Entity Compliance Officer</td>
<td>Barbara Morrow</td>
<td>Will fill Compliance Officer role is completed until NCI Compliance Officer is in place. Will provide oversight to NCI Compliance Officer</td>
</tr>
<tr>
<td>Regional Chief Information Officer (CIO)</td>
<td>Corey M. Zeigler</td>
<td>EMR, HIE, PCMH, PHM Gap Analysis Executed/approved plans for EMR, HIE, PHM and PCMH</td>
</tr>
<tr>
<td>Data, Infrastructure, and Security Lead</td>
<td>Chris Grieco, FDRHPO Chief Security Officer</td>
<td>Data security and confidentiality plan, Data Exchange Plan</td>
</tr>
<tr>
<td>Regional PCMH Project Lead</td>
<td>Liza Darou, RN, PCMH-CCE</td>
<td>Lead PCMH Implementation Plan Lead Workflow Process Change Initiatives for Primary Care Nurse Informatics</td>
</tr>
<tr>
<td>RHIO/HIE</td>
<td>Rob Hack, HealtheConnections RHIO</td>
<td>Providing HIE interoperability for the PPS region</td>
</tr>
<tr>
<td>Technical lead(s)</td>
<td>IT Champions</td>
<td>Main driver at each participant site for operational deliverables</td>
</tr>
<tr>
<td>Clinical Champion</td>
<td>Provider Champions</td>
<td>Main driver at each participant site for provider engagement</td>
</tr>
<tr>
<td>Workforce Project Lead</td>
<td>Tracy Leonard</td>
<td>Lead the development of the PPS Workforce Assessment and Strategy</td>
</tr>
</tbody>
</table>
### Samaritan Medical Center (PPS ID: 45)

<table>
<thead>
<tr>
<th>Role</th>
<th>Name of person / organization (if known at this stage)</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSRIP Planning and Facilitation</td>
<td>Denise Young</td>
<td>Lead the overall DSRIP Planning Effort</td>
</tr>
<tr>
<td>North Country Health Home</td>
<td>Health Home</td>
<td>Health Home Care Management</td>
</tr>
<tr>
<td>Iroquois Healthcare Association</td>
<td>Workforce Vendor</td>
<td>Data collection and reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Training and Education partnership</td>
</tr>
<tr>
<td>Northern Area Health Education Center</td>
<td>Workforce Vendor</td>
<td>Training and Education partnership</td>
</tr>
</tbody>
</table>
### IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects

**Instructions:**

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

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal Stakeholders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Country Initiative, LLC  Board of Managers</td>
<td>Governance</td>
<td>Oversight and success of all DSRIP Activities, Policy and Plan Adoption and Executive Sponsorship, Physician and Provider Champions and Leadership, Overall DSRIP Performance Monitoring</td>
</tr>
<tr>
<td>DSRIP Project Advisory Committee</td>
<td>Multi-organizational</td>
<td>Review and make recommendations to the NCI Board on DSRIP strategies and Plans</td>
</tr>
<tr>
<td>NCI Medical Management (Clinical) Committee</td>
<td>Clinical Governance</td>
<td>Clinical Oversight for DSRIP Projects, Clinical Guideline &amp; Protocol Development and Support, Clinical Champions, Quality of Care and Patient Outcomes, PHM Disease Registry Quality Measures - Performance Monitoring</td>
</tr>
<tr>
<td>NCI HIT Governance Committee</td>
<td>HIT Assessment, Plan, Adoption</td>
<td>Responsible for reviewing HIT Gap Analysis and Plans, Championing adoption by clinicians, Patient-Centered Medical Home implementation plan, EMR and MU, PHM Disease Registry roll-out</td>
</tr>
<tr>
<td>NCI Compliance Committee</td>
<td>Compliance</td>
<td>Responsible to ensure Compliance Plans, Policies and Training are in place including Lead Entity Compliance Plan consistent with New York State Social Services Law 363-d</td>
</tr>
<tr>
<td>NCI Health Literacy &amp; Cultural Competency Committee</td>
<td>Health Literacy &amp; Cultural Competency Plans</td>
<td>Development of Health Literacy and Cultural Competency Strategy, Development and oversight of Health Literacy and Cultural Competency Training Plan in partnership with Workforce Committee</td>
</tr>
<tr>
<td>NCI Provider Recruitment, GME &amp; Workforce Governance Committee</td>
<td>Workforce</td>
<td>Physician/Provider Recruitment Plan, GME Expansion Analysis</td>
</tr>
</tbody>
</table>
## Key stakeholders

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
</table>
| NCI Care Coordination Committee | Care Coordination across continuum of care | Workforce Roadmap Adoption
Workforce Training Strategy Adoption |
| Behavioral Health Committee (FDRHPO) | Behavioral Health Integration 2.a.i
Strengthen BH Infrastructure 4.a.iii | Planning and support for Behavioral Health strategies across PPS including integration of Primary Care and Behavioral Health, Strengthening Behavioral Health Infrastructure, Behavioral Health Care Transitions |
| North Country Health Compass Committee | Population Health Improvement Program bridge | Identifying Neighborhood and community needs
Hot Spotting
Population Health
Health Disparities
PAM navigation priority |
| Workforce Strategies Committee (FDRHPO) | Workforce Planning | Develop Workforce Gap Analysis
Develop Workforce Roadmap
Develop Workforce Strategy |
| Safety Net hospital partners | Active Participation | Participate on Committees
Champion activities
Adopt and participate in plans and training as applicable
Actively carry out deliverables |
| All PPS Partners | Active Participation | Participate on Committees
Champion activities
Adopt and participate in plans and training as applicable
Actively carry out deliverables |
| All PPS Partners | Actively carry out deliverables | Participate on Committees
Champion activities
Adopt and participate in plans and training as applicable
Actively carry out deliverables |
| External Stakeholders | | |
| Fort Drum Regional Health Planning Organization | Financial Plan Assistance
IT infrastructure
Contracted PMO Staffing and Support,
Coordination of Activities | IT/Data Partnership
Facilitation of Activities
Continuity & Credibility |
| Managed Care Organizations | MCCs identified by PPS for pursuit of PPS Value based reform strategies | The PPS Lead and PPS will have responsibilities related to implementing the PPSs value based strategy |
| Non-Partner Community Based Organizations | Engagement and Recipients of communication plans. | Understanding and buy-in |
### Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Key stakeholders</th>
<th>Role in relation to this organizational workstream</th>
<th>Key deliverables / responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid and Uninsured Patients, Community Members</td>
<td>Engagement to ensure positive impact on beneficiaries. Recipients of communication plans.</td>
<td>Information to ensure projects and activities are effective and appropriately targeted</td>
</tr>
</tbody>
</table>
IPQR Module 10.5 - IA Monitoring

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

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

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

1. Risk: Collecting participant level data from PPS partners
   Mitigation: a) Utilize centralized platform to help manage project planning, implementation, monitoring and reporting with real-time data
   b) A standardized process (reporting, timelines, rollout, etc.) will ensure appropriate individuals are aware of when and how trainings will be delivered to ensure we are meeting milestones in alignment with project speed.
   c) Engage staff educators, human resource personnel and management to monitor the entities progress towards achieving milestones.

2. Risk: Retaining and applying DSRIP training requirements across PPS
   Mitigation: a) Prioritized timeline based on project speed to ensure training information directly applied
   b) Transparent communication with project partners to facilitate their understanding of what, why and how, and in turn they are informing the process
   c) Active involvement on committees to assist with planning and implementation
   d) Assist employees and entities to balance the responsibilities and needs of their day-to-day operations with PPS training requirements

3. Risk: Implementation of ICD-10 coding in October 2015 may temporarily shift provider priorities, as payments to providers hinges on accurate coding. Time and resources will need to be spent to train and prepare practices for this conversion, otherwise, practices could experience a potentially devastating loss of productivity and revenue- enough to jeopardize the financial stability of a practice. The primary changes in ICD-10 are related to organization and structure, code composition, and increased level of detail related to documentation. The time needed to provide the additional documentation support to support the patient's diagnosis could present challenges to IT and PCMH rollouts as well as Provider engagement and training especially in our already lean practices.
   Mitigation: a) Establish a group to assess and monitor ICD-10 provider readiness and its potential impact on the implementation of chosen projects
   b) Develop contingency plan in the event that provider focus shifts to ICD-10 implementation

4. Risk: Primary Care Physician Shortages: Rural, Federally designated Health Professional Shortage Area (HPSA). This challenge of being rural is further exacerbated by harsh winters and limited financial resources to incentivize providers to come and stay in our region. The recruitment and retention of physician and physician extenders to include behavioral health and dental providers remains a significant challenge.
   Mitigation: a) Investment of dollars to incentivize providers, especially those who will serve the Medicaid population
   b) Creation of workforce committee who will focus on GME expansion, physician education and provider recruitment/retention strategies
   c) Increase awareness of, and alignment with federal and state initiative

5. Risk: Disparate IT Systems and capability of EMRs across PPS and particular workstreams with no or little EMR capability (i.e. BH, CBOs, LTC)

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Mitigation: a) Comprehensive needs assessment
b) Staged plan for implementation encompassing largest volume Safety Net providers first
IPQR Module 2.a.i.2 - Project Implementation Speed

Instructions:

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>78</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>264</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospitals</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinics</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>43</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Skilled Nursing Facilities / Nursing Homes</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospice</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>126</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Committed Providers</strong></td>
<td><strong>577</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Percent Committed Providers (%)</strong></td>
<td></td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year, Quarter (DY3,Q3 – DY5,Q4)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY3,Q3</td>
<td>DY3,Q4</td>
</tr>
<tr>
<td>Hospitals</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinics</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>43</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Skilled Nursing Facilities / Nursing Homes</td>
<td>11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hospice</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>17</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>126</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Committed Providers</strong></td>
<td><strong>577</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Percent Committed Providers(%)</strong></td>
<td></td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

### Current File Uploads

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

No Records Found

**Narrative Text:**

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

Samaritan Medical Center (PPS ID:45)

Instructions:

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

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Task 1. Create a comprehensive Sharepoint master database of all participating providers/partners within the PPS network list</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>07/30/2015</td>
<td>07/30/2015</td>
<td>03/31/2018</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td>Task 2. Assign responsibility for maintaining/updating list</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>03/31/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td>Task 3. Ensure all critical areas are included in list</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task 4. Develop participation agreements</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td>Task 5. Execute agreements</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Milestone #2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPS produces a list of participating HHs and ACOs.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

NYS Confidentiality – High
## Project Requirements

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Develop and maintain list of participating HH and ACOs.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>2. Integrate Health Home and ACO into PPS Population Health Management strategy for Integrated Delivery System</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>3. Develop regularly scheduled meetings which include the Health Home and ACO</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>4. Create an IDS strategic plan that aligns the ACO, Health Home (HH) and Clinically Integrated Network (CIN) with shared protocols, measures and goals to achieve the objectives of the IDS population health management strategy.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Clinically Interoperable System is in place for all participating providers.</td>
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<td></td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.</td>
<td>Project</td>
<td></td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>PPS trains staff on IDS protocols and processes.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>1. Identify appropriate partners for HIE</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2016</td>
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<td>DY1 Q4</td>
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<tr>
<td>2. Identify workflow changes to create integrated system</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
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<tr>
<td>3. Develop process workflow diagrams demonstrating IDS processes including responsible providers</td>
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<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
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<td>4. Identify process to track post-hospitalization discharge plan follow-up care and appointment reminders are followed</td>
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<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<tr>
<td>5. Identify critical positions within IDS for training</td>
<td>Project</td>
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<td>04/01/2015</td>
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<td>06/30/2016</td>
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<td>6. Develop training materials on integrated delivery system workflow and process</td>
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<td>12/31/2016</td>
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<td>End Date</td>
<td>Quarter End Date</td>
<td>DS R I P Reporting Year and Quarter</td>
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<tr>
<td>7. Conduct/facilitate training on IDS workflow and roles</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<td><strong>Milestone #4</strong></td>
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<tr>
<td>Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<td><strong>Task</strong></td>
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<tr>
<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Non-PCP Practitioners</td>
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<tr>
<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Hospitals</td>
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<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td>Safety Net Behavioral Health</td>
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<td>03/31/2020</td>
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<tr>
<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Skilled Nursing Facilities / Nursing Homes</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
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<td>PPS uses alerts and secure messaging functionality.</td>
<td>Project</td>
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<td>04/01/2015</td>
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<td>03/31/2018</td>
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<td>DY3 Q4</td>
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<tr>
<td><strong>Task</strong></td>
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<td>1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.</td>
<td>Project</td>
<td>In Progress</td>
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<td>03/31/2016</td>
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<td>DY1 Q4</td>
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<tr>
<td>2. Perform a gap analysis and a plan with budget to address the identified needs</td>
<td>Project</td>
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<td>03/31/2016</td>
<td>03/31/2016</td>
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<td>DY1 Q4</td>
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<tr>
<td>3. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
<td>Project</td>
<td>In Progress</td>
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<td>03/31/2016</td>
<td>03/31/2016</td>
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<td>DY1 Q4</td>
</tr>
<tr>
<td>4. During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, &amp; issues are communicated and a plan is in place to address them.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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<td>DY2 Q1</td>
</tr>
<tr>
<td>5. Perform a post-go-live gap analysis and a plan with budget to address the identified needs</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<td>DY2 Q4</td>
</tr>
<tr>
<td>6. Facilitate the practice's connection with the HealtheConnections RHIO and</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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</table>
## Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>The regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</th>
</tr>
</thead>
</table>

### Milestone #5

**Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.**

- **Project**
- **Status**: In Progress
- **Start Date**: 04/01/2015
- **End Date**: 03/31/2018
- **Quarter End Date**: 03/31/2018
- **DSRIP Reporting Year and Quarter**: 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**
  - **Status**: In Progress
  - **Start Date**: 04/01/2015
  - **End Date**: 03/31/2018
  - **Quarter End Date**: 03/31/2018
  - **DSRIP Reporting Year and Quarter**: DY3 Q4

### Task

- **PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.**
  - **Provider**
  - **Safety Net Primary Care Physicians**
  - **Status**: On Hold
  - **Start Date**: 04/01/2015
  - **End Date**: 03/31/2020
  - **Quarter End Date**: 03/31/2020
  - **DSRIP Reporting Year and Quarter**: DY5 Q4

### Task

1. **Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.**
   - **Project**
   - **Status**: In Progress
   - **Start Date**: 04/01/2015
   - **End Date**: 03/31/2016
   - **Quarter End Date**: 03/31/2016
   - **DSRIP Reporting Year and Quarter**: DY1 Q4

2. **Perform a gap analysis and a plan with budget to address the identified needs.**
   - **Project**
   - **Status**: In Progress
   - **Start Date**: 04/01/2015
   - **End Date**: 03/31/2016
   - **Quarter End Date**: 03/31/2016
   - **DSRIP Reporting Year and Quarter**: DY1 Q4

3. **Begin implementations with prioritization based on attributed Medicaid population and provider engagement.**
   - **Project**
   - **Status**: In Progress
   - **Start Date**: 04/01/2015
   - **End Date**: 03/31/2016
   - **Quarter End Date**: 03/31/2016
   - **DSRIP Reporting Year and Quarter**: DY1 Q4

4. **During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, & issues are communicated and a plan is in place to address them.**
   - **Project**
   - **Status**: In Progress
   - **Start Date**: 04/01/2015
   - **End Date**: 06/30/2016
   - **Quarter End Date**: 06/30/2016
   - **DSRIP Reporting Year and Quarter**: DY2 Q1

5. **Perform a post-go-live gap analysis and a plan with budget to address the identified needs.**
   - **Project**
   - **Status**: In Progress
   - **Start Date**: 04/01/2015
   - **End Date**: 03/31/2017
   - **Quarter End Date**: 03/31/2017
   - **DSRIP Reporting Year and Quarter**: DY2 Q4

6. **Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.**
   - **Project**
   - **Status**: In Progress
   - **Start Date**: 04/01/2015
   - **End Date**: 03/31/2018
   - **Quarter End Date**: 03/31/2018
   - **DSRIP Reporting Year and Quarter**: DY3 Q4

7. **Perform a pre-MU and PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH.**
   - **Project**
   - **Status**: In Progress
   - **Start Date**: 04/01/2015
   - **End Date**: 03/31/2016
   - **Quarter End Date**: 03/31/2016
   - **DSRIP Reporting Year and Quarter**: DY1 Q4

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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
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<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>in order to attest for MU and apply for NCQA PCMH by DSRIP DY3.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
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<tr>
<td><strong>Task</strong> 8. Begin MU attestations &amp; PCMH recognitions with prioritization based on attributed Medicaid population and provider engagement.</td>
<td>Project</td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<td><strong>Milestone #6</strong></td>
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<tr>
<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
<td>Project</td>
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<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td><strong>Task</strong> PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.</td>
<td>Project</td>
<td>In Progress</td>
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<td>03/31/2016</td>
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<tr>
<td><strong>Task</strong> 2. Perform a gap analysis and a plan with budget to address the identified needs</td>
<td>Project</td>
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<tr>
<td><strong>Task</strong> 3. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
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<tr>
<td><strong>Task</strong> 4. During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, &amp; issues are communicated and a plan is in place to address them</td>
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<td>06/30/2016</td>
<td>06/30/2016</td>
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<tr>
<td><strong>Task</strong> 5. Perform a post-go-live gap analysis and a plan with budget to address the identified needs</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
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<td></td>
</tr>
<tr>
<td><strong>Task</strong> 6. Facilitate the practice's connection with the regional PHM platform to ensure the providers have access to quality measures and the ability to risk stratify their population in order to provide efficient, effective and high-quality care.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td><strong>Task</strong> 7. Perform a continual improvement (PDSA) cycle in order to improve documentation and other processes to target gaps in care for high risk patients.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td><strong>Milestone #7</strong> Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use objectives.</td>
<td>Project</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

<table>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<td>Use standards by the end of DY 3.</td>
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<td>Task Primary care capacity increases improved access for patients seeking services particularly in high-need areas.</td>
<td>Provider Type</td>
<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
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<td>All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.</td>
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<td>03/31/2020</td>
<td>03/31/2020</td>
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<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)</td>
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<tr>
<td>Task 1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.</td>
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<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>Task 2. Perform a gap analysis and a plan with budget to address the identified needs</td>
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<td>03/31/2016</td>
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<tr>
<td>Task 3. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
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<tr>
<td>Task 5. Perform a post-go-live gap analysis and a plan with budget to address the identified needs</td>
<td>Project</td>
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<td>DY3 Q4</td>
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</tr>
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<td>Task 7. Perform a pre-MU and PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to attest for MU and apply for NCQA PCMH by DSRIP DY3.</td>
<td>Project</td>
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<td>Task 8. Begin MU attestations &amp; PCMH recognitions with prioritization based on</td>
<td>Project</td>
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<td>12/31/2016</td>
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### Samaritan Medical Center (PPS ID: 45)

<table>
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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>End Date</th>
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<tr>
<td>attributed Medicaid population and provider engagement.</td>
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<tr>
<td><strong>Milestone #6</strong> Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.</td>
<td>Project</td>
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<tr>
<td><strong>Task</strong> Medicaid Managed Care contract(s) are in place that include value-based payments.</td>
<td>Project</td>
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<tr>
<td>1. Develop Value-based payment work plan as delineated under the Financial Sustainability Plan</td>
<td>Project</td>
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<td>07/01/2015</td>
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<td><strong>Task</strong> Develop timeline for VBP adoption as delineated under the Financial Sustainability Section</td>
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<td>3. Finalize VBP Adoption Plan as delineated under Financial Sustainability Section</td>
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<td><strong>Milestone #9</strong> Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.</td>
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<tr>
<td><strong>Task</strong> PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.</td>
<td>Project</td>
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<td>04/01/2015</td>
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<td>1. Identify Medicaid MCOs in PPS service area</td>
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<td><strong>Task</strong> Outreach to Medicaid MCOs for initial meeting</td>
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<td><strong>Task</strong> Establish monthly meeting schedule with MCO to evaluate utilization trends and performance issues to ensure payment reforms are instituted</td>
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<td>4. Develop an agenda for meetings with MCOs to discuss a first draft business case that is in the interests of both organizations.</td>
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<td><strong>Milestone #10</strong> Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.</td>
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<td><strong>Task</strong> PPS submitted a growth plan outlining the strategy to evolve provider</td>
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### Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter |
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**compensation model to incentive-based compensation**

**Task** Providers receive incentive-based compensation consistent with DSRIP goals and objectives.

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<th>Reporting Level</th>
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**Task** 1. Develop plan to evolve provider compensation model to incentive based compensation

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**Task** 2. Ensure plan includes incentives based on DSRIP project goals and achievements

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**Task** 3. Implement compensation and performance management system utilizing PHM system to drive incentive/compensation reward for positive quality improvement and improved patient outcomes

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**Milestone #11** Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.

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

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**Task** 1. Identify community based organizations for outreach and navigation

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**Task** 2. Partner with Population Health Improvement Program for neighborhood hotspotting and neighborhood coalition building

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**Task** 3. Conduct Community Health Worker training

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**Task** 4. Conduct PAM training for Community Based Organizations and partners

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**Task** 5. Facilitate community health worker neighborhood patient outreach and engagement activities in partnership with PHIP

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<td>03/31/2017</td>
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**Task** 6. Develop appropriate outreach materials in partnership with Health Literacy and Cultural Competency Committee

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<tr>
<th>Reporting Level</th>
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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**
All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.

**Task**
- PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.

**Task**
- 1. Create a comprehensive SharePoint master database of all participating providers/partners within the PPS network list

**Task**
- 2. Assign responsibility for maintaining/updating list

**Task**
- 3. Ensure all critical areas are included in list

**Task**
- 4. Develop participation agreements

**Task**
- 5. Execute agreements

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

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

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

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

**Task**
- 1. Develop and maintain list of participating HH and ACOs.

**Task**
- 2. Integrate Health Home and ACO into PPS Population Health Management strategy for Integrated Delivery System

**Task**
- 3. Develop regularly scheduled meetings which include the Health Home and ACO

**Task**
- 4. Create an IDS strategic plan that aligns the ACO, Health
### Project Requirements

<table>
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<tr>
<th>Milestone/Task Name</th>
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<th>DY1,Q2</th>
<th>DY1,Q3</th>
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<tr>
<td>Home (HH) and Clinically Integrated Network (CIN) with shared protocols, measures and goals to achieve the objectives of the IDS population health management strategy.</td>
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<tr>
<td>Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.</td>
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<tr>
<td>Task Clinically Interoperable System is in place for all participating providers.</td>
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<tr>
<td>Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.</td>
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<tr>
<td>Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.</td>
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<td>Task PPS trains staff on IDS protocols and processes.</td>
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<td>Task 1. Identify appropriate partners for HIE</td>
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<td>Task 2. Identify workflow changes to create integrated system</td>
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<td>Task 3. Develop process workflow diagrams demonstrating IDS processes including responsible providers</td>
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<td>Task 4. Identify process to track post-hospitalization discharge plan follow-up care and appointment reminders are followed</td>
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<td>Task 6. Develop training materials on integrated delivery system workflow and process</td>
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<td>Task 7. Conduct/facilitate training on IDS workflow and roles</td>
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<tr>
<td>Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.</td>
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**NYS Confidentiality – High**
# Samaritan Medical Center (PPS ID: 45)

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<td>PPS uses alerts and secure messaging functionality.</td>
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<td>Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards</td>
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<td>and/or APCM by the end of Demonstration Year 3.</td>
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<td><strong>Task</strong> 2. PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
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<td><strong>Task</strong> 3. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.</td>
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<td><strong>Task</strong> 8. Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</td>
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<td><strong>Task</strong> 9. Perform a pre-MU and PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to attest for MU and apply for NCQA PCMH by DSRIP DY3.</td>
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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name)

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<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
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<td>Task</td>
<td>PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.</td>
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<td>Task 6.</td>
<td>Facilitate the practice's connection with the regional PHM platform to ensure the providers have access to quality measures and the ability to risk stratify their population in order to provide efficient, effective and high-quality care.</td>
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<td>Task 7.</td>
<td>Perform a continual improvement (PDSA) cycle in order to improve documentation and other processes to target gaps in care for high risk patients.</td>
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<td>Milestone #7</td>
<td>Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.</td>
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<td>Task</td>
<td>Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.</td>
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<td>All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.</td>
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<td>Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish</td>
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### Samaritan Medical Center (PPS ID:45)

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<td>value-based payment arrangements.</td>
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<td>Medicaid Managed Care contract(s) are in place that include value-based payments.</td>
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<td>1. Develop Value-based payment work plan as delineated under the Financial Sustainability Plan</td>
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<td>2. Develop timeline for VBP adoption as delineated under the Financial Sustainability Section</td>
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<td>3. Finalize VBP Adoption Plan as delineated under Financial Sustainability Section</td>
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<td>Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.</td>
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<td>PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.</td>
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<td>1. Identify Medicaid MCOs in PPS service area</td>
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<td>2. Outreach to Medicaid MCOs for initial meeting</td>
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<td>3. Establish monthly meeting schedule with MCO to evaluate utilization trends and performance issues to ensure payment reforms are instituted</td>
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<td>4. Develop an agenda for meetings with MCOs to discuss a first draft business case that is in the interests of both organizations.</td>
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<td>Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.</td>
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<td>PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation</td>
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<td>Providers receive incentive-based compensation consistent with DSRIP goals and objectives.</td>
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<td>1. Develop plan to evolve provider compensation model to incentive-based compensation</td>
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## Samaritan Medical Center (PPS ID:45)

### Project Requirements

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<tr>
<td>Task 2. Ensure plan includes incentives based on DSRIP project goals and achievements</td>
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<td>Task 3. Implement compensation and performance management system utilizing PHM system to drive incentive/compensation reward for positive quality improvement and improved patient outcomes</td>
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### Milestone #1

Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.

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<th>Task</th>
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<th>DY3,Q4</th>
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<tr>
<td>Task 1. Identify community based organizations for outreach and navigation</td>
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<td>Task 2. Partner with Population Health Improvement Program for neighborhood hotspotting and neighborhood coalition building</td>
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<td>Task 4. Conduct PAM training for Community Based Organizations and partners</td>
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<td>Task 5. Facilitate community health worker neighborhood patient outreach and engagement activities in partnership with PHIP</td>
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<td>Task 6. Develop appropriate outreach materials in partnership with Health Literacy and Cultural Competency Committee</td>
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### Milestone #2

All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.

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<th>Milestone/Task Name</th>
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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
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---

**PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.**

**Task**
1. Create a comprehensive Sharepoint master database of all participating providers/partners within the PPS network list

**Task**
2. Assign responsibility for maintaining/updating list

**Task**
3. Ensure all critical areas are included in list

**Task**
4. Develop participation agreements

**Task**
5. Execute agreements

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

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

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

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

**Task**
1. Develop and maintain list of participating HH and ACOs.

**Task**
2. Integrate Health Home and ACO into PPS Population Health Management strategy for Integrated Delivery System

**Task**
3. Develop regularly scheduled meetings which include the Health Home and ACO

**Task**
4. Create an IDS strategic plan that aligns the ACO, Health Home (HH) and Clinically Integrated Network (CIN) with shared protocols, measures and goals to achieve the objectives of the IDS population health management strategy.

**Milestone #3**
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.

NYS Confidentiality – High
## Samaritan Medical Center (PPS ID:45)

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<td>Clinically Interoperable System is in place for all participating providers.</td>
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<td>PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.</td>
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<td>PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.</td>
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<td>PPS trains staff on IDS protocols and processes.</td>
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<td>2. Identify workflow changes to create integrated system</td>
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<td>3. Develop process workflow diagrams demonstrating IDS processes including responsible providers</td>
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<td>4. Identify process to track post-hospitalization discharge plan follow-up care and appointment reminders are followed</td>
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<td>5. Identify critical positions within IDS for training</td>
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<td>6. Develop training materials on integrated delivery system workflow and process</td>
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<td>7. Conduct/facilitate training on IDS workflow and roles</td>
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<td>Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

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<td>PPS uses alerts and secure messaging functionality.</td>
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<td>1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.</td>
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<td>2. Perform a gap analysis and a plan with budget to address the identified needs</td>
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<td>3. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
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<td>6. Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</td>
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<td>Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.</td>
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<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
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<td>PPS has achieved NCQA 2014 Level 3 PCMH standards</td>
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NYS Confidentiality – High
### Project Requirements

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<td>and/or APCM.</td>
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<td>Task 7. Perform a pre-MU and PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to attest for MU and apply for NCQA PCMH by DSRIP DY3.</td>
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<tr>
<td>Task 8. Begin MU attestations &amp; PCMH recognitions with prioritization based on attributed Medicaid population and provider engagement.</td>
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#### 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.
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID: 45)

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<th>Project Requirements</th>
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<td><strong>Task</strong> 2. Perform a gap analysis and a plan with budget to address the identified needs</td>
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<td><strong>Task</strong> 6. Facilitate the practice’s connection with the regional PHM platform to ensure the providers have access to quality measures and the ability to risk stratify their population in order to provide efficient, effective and high-quality care.</td>
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<td><strong>Task</strong> 7. Perform a continual improvement (PDSA) cycle in order to improve documentation and other processes to target gaps in care for high-risk patients.</td>
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**Milestone #7**

Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.

**Task**

Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.

**Task**

All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.

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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.)

NYS Confidentiality – High
### Samaritan Medical Center (PPS ID:45)

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<td>Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.</td>
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<td>Task Medicaid Managed Care contract(s) are in place that include value-based payments.</td>
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<td>Task 1. Develop Value-based payment work plan as delineated under the Financial Sustainability Plan</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

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<tr>
<td><strong>Task</strong> 2. Develop timeline for VBP adoption as delineated under the Financial Sustainability Section</td>
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<td><strong>Task</strong> 3. Finalize VBP Adoption Plan as delineated under Financial Sustainability Section</td>
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<td><strong>Milestone #9</strong> Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.</td>
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<td><strong>Task</strong> PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.</td>
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<td><strong>Task</strong> 1. Identify Medicaid MCOs in PPS service area</td>
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<td><strong>Task</strong> 2. Outreach to Medicaid MCOs for initial meeting</td>
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<td><strong>Task</strong> 3. Establish monthly meeting schedule with MCO to evaluate utilization trends and performance issues to ensure payment reforms are instituted</td>
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<td><strong>Task</strong> 4. Develop an agenda for meetings with MCOs to discuss a first draft business case that is in the interests of both organizations.</td>
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<td><strong>Milestone #10</strong> Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.</td>
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<td><strong>Task</strong> PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation</td>
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<td><strong>Task</strong> Providers receive incentive-based compensation consistent with DSRIP goals and objectives.</td>
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<td><strong>Task</strong> 1. Develop plan to evolve provider compensation model to incentive based compensation</td>
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<td><strong>Task</strong> 2. Ensure plan includes incentives based on DSRIP project goals and achievements</td>
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<td><strong>Task</strong> 3. Implement compensation and performance management system utilizing PHM system to drive incentive/compensation reward for positive quality improvement and improved patient outcomes</td>
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<td>Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.</td>
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<td>Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.</td>
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<td>2. Partner with Population Health Improvement Program for neighborhood hotspotting and neighborhood coalition building</td>
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<td>5. Facilitate community health worker neighborhood patient outreach and engagement activities in partnership with PHIP</td>
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<tr>
<td>6. Develop appropriate outreach materials in partnership with Health Literacy and Cultural Competency Committee</td>
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## Prescribed Milestones Current File Uploads

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## Prescribed Milestones Narrative Text

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<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.</td>
<td></td>
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</tbody>
</table>
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS’ strategy towards evolving into an IDS.</td>
<td></td>
</tr>
<tr>
<td>Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.</td>
<td></td>
</tr>
<tr>
<td>Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.</td>
<td></td>
</tr>
<tr>
<td>Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.</td>
<td></td>
</tr>
<tr>
<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
<td></td>
</tr>
<tr>
<td>Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.</td>
<td></td>
</tr>
<tr>
<td>Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.</td>
<td></td>
</tr>
<tr>
<td>Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.</td>
<td></td>
</tr>
<tr>
<td>Re-enforce the transition towards value-based payment reform by aligning provider compensation</td>
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### Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
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<tr>
<td>to patient outcomes.</td>
<td></td>
</tr>
<tr>
<td>Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.</td>
<td></td>
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</tbody>
</table>
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

✅ IPQR Module 2.a.i.4 - PPS Defined Milestones

Instructions:

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

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

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PPS Defined Milestones Narrative Text

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

Instructions:
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.

1. Risk: Collecting participant level data from PPS partners
   Mitigation: a) Utilize centralized platform to help manage project planning, implementation, monitoring and reporting with real-time data
   b) A standardized process (reporting, timelines, rollout, etc.) will ensure appropriate individuals are aware of the deliverables to ensure we are meeting milestones in alignment with project speed.

2. Risk: Implementation of ICD-10 coding in October 2015 may temporarily shift provider priorities, as payments to providers hinges on accurate coding. Time and resources will need to be spent to train and prepare practices for this conversion, otherwise, practices could experience a potentially devastating loss of productivity and revenue - enough to jeopardize the financial stability of a practice. The primary changes in ICD-10 are related to organization and structure, code composition, and increased level of detail related to documentation. The time needed to provide the additional documentation support to support the patient's diagnosis could present challenges to IT and PCMH rollouts as well as Provider engagement and training especially in our already lean practices.
   Mitigation: a) Establish a group to assess and monitor ICD-10 provider readiness and its potential impact on the implementation of chosen projects
   b) Develop contingency plan in the event that provider focus shifts to ICD-10 implementation

3. Risk: Primary Care Physician Shortages: Rural, Federally designated Health Professional Shortage Area (HPSA).
   Mitigation: a) Ensure providers are supported by staff to ensure their activities are value-added and not staff-level tasks that can be delegated
   b) Ensure the EHRs are optimized to efficiently support clinical workflow
   c) Leverage community assets to support the medical home model.

4. Risk: Disparate IT Systems and capability of EMRs across PPS and particular workstreams with no or little EMR capability (i.e. BH, CBOs, LTC)
   Mitigation: a) Comprehensive needs assessment
   b) Staged plan for implementation encompassing largest volume Safety Net providers first

5. Risk: Shortage of NCQA PCMH Content experts to support the primary care practice transformations
   Mitigation: a) Comprehensive needs assessment
   b) Staged plan for implementation encompassing largest volume Safety Net providers first
Instructions:

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
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<tr>
<td>Primary Care Physicians</td>
<td>78</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Clinics</td>
<td>18</td>
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<tr>
<td>Total Committed Providers</td>
<td>96</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Percent Committed Providers(%)</td>
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<td>0.00</td>
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Current File Uploads

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Narrative Text:

NYS Confidentiality – High
### IPQR Module 2.a.ii.3 - Patient Engagement Speed

**Instructions:**

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

#### Benchmarks

<table>
<thead>
<tr>
<th>100% Actively Engaged By</th>
<th>Expected Patient Engagement</th>
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<tbody>
<tr>
<td>DY3,Q4</td>
<td>19,977</td>
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#### Year,Quarter (DY1,Q1 – DY3,Q2)

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>5,000</td>
<td>7,500</td>
<td>10,000</td>
<td>2,000</td>
<td>4,000</td>
<td>7,500</td>
<td>10,000</td>
<td>5,000</td>
<td>9,989</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>0.00</td>
<td>25.03</td>
<td>37.54</td>
<td>50.06</td>
<td>10.01</td>
<td>20.02</td>
<td>37.54</td>
<td>50.06</td>
<td>25.03</td>
<td>50.00</td>
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#### Year,Quarter (DY3,Q3 – DY5,Q4)

<table>
<thead>
<tr>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>15,000</td>
<td>19,977</td>
<td>5,000</td>
<td>9,989</td>
<td>15,000</td>
<td>19,977</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>75.09</td>
<td>100.00</td>
<td>25.03</td>
<td>50.00</td>
<td>75.09</td>
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**Narrative Text:**

NYS Confidentiality – High
### IPQR Module 2.a.ii.4 - Prescribed Milestones

Instructions:

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

<table>
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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong> 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.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td><strong>Task</strong> All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td><strong>Task</strong> a. Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td><strong>Task</strong> a.i. Phase 1 PCPs complete</td>
<td>Project</td>
<td></td>
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<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<td><strong>Task</strong> a.ii. Phase 2 PCPs complete</td>
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<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
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<td><strong>Task</strong> a.iii. Phase 3 PCPs complete</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> b. Preform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
<td>Project</td>
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<td>In Progress</td>
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<td>03/31/2016</td>
<td>03/31/2016</td>
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<td><strong>Task</strong> b.i. Phase 1 PCPs complete</td>
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<td><strong>Task</strong> b.ii. Phase 2 PCPs complete</td>
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<td>12/31/2015</td>
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<td><strong>Task</strong> b.iii. Phase 3 PCPs complete</td>
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<td>03/31/2016</td>
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<tr>
<td><strong>Task</strong> c. Create a project plan/timeline for each PCP</td>
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<td>03/31/2016</td>
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<td><strong>Task</strong> c.i. Phase 1 PCPs complete</td>
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<td>12/31/2015</td>
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<td><strong>Task</strong> c.ii. Phase 2 PCPs complete</td>
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New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

<table>
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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>d. Implement the PCMH processes, procedures, protocols and written policies.</td>
<td>Project</td>
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<td>In Progress</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2017</td>
<td>09/30/2017</td>
<td>DY3 Q2</td>
</tr>
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<td>Task d.iii. Phase 3 PCPs complete</td>
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<td>12/31/2017</td>
<td>12/31/2017</td>
<td>DY3 Q3</td>
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<tr>
<td>Task e. Complete the NCQA Level 3 PCMH submissions</td>
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<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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<td>Task e.i. Phase 1 PCPs complete</td>
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<td>04/01/2015</td>
<td>09/30/2017</td>
<td>09/30/2017</td>
<td>DY3 Q2</td>
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<tr>
<td>Task e.ii. Phase 2 PCPs complete</td>
<td>Project</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2017</td>
<td>12/31/2017</td>
<td>DY3 Q3</td>
</tr>
<tr>
<td>Task e.iii. Phase 3 PCPs complete</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Task f. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates</td>
<td>Project</td>
<td></td>
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<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Task f.i. Phase 1 PCPs complete</td>
<td>Project</td>
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<td>In Progress</td>
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<td>09/30/2017</td>
<td>09/30/2017</td>
<td>DY3 Q2</td>
</tr>
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<td>Task f.ii. Phase 2 PCPs complete</td>
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<td>04/01/2015</td>
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<td>12/31/2017</td>
<td>DY3 Q3</td>
</tr>
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<td>Task f.iii. Phase 3 PCPs complete</td>
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<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Milestone #2 Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task PPS has identified physician champion with experience implementing PCMHs/APCMs.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td>Task a.i. Phase 1 PCP Practices identifies physician champion</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<td>Project</td>
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<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td>Task a.iii. Phase 3 PCPs Practices identifies physician champion</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>Task f. Identified Physician Champion representing each primary care practice will sign memorandum stating said role.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
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</table>
### Project Requirements

<table>
<thead>
<tr>
<th>Milestone #3</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task</td>
<td>Care coordinators are identified for each primary care site.</td>
</tr>
<tr>
<td>Provider Type</td>
<td>Primary Care Physicians</td>
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<tr>
<td>Status</td>
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<td>Start Date</td>
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<td>End Date</td>
<td>03/31/2020</td>
</tr>
<tr>
<td>Quarter</td>
<td>DY5 Q4</td>
</tr>
</tbody>
</table>

| Task         | Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities. |
| Provider Type| Primary Care Physicians |
| Status       | On Hold |
| Start Date   | 04/01/2015 |
| End Date     | 03/31/2020 |
| Quarter      | DY5 Q4 |

| Task         | Clinical Interoperability System in place for all participating providers and document usage by the identified care coordinators. |
| Provider Type| N/A |
| Status       | In Progress |
| Start Date   | 04/01/2015 |
| End Date     | 03/31/2017 |
| Quarter      | DY2 Q4 |

| Task         | 1. Identified Care Coordinators at each primary care site will sign memorandum stating said role. |
| Provider Type| N/A |
| Status       | In Progress |
| Start Date   | 04/01/2015 |
| End Date     | 03/31/2017 |
| Quarter      | DY2 Q4 |

| Task         | 2. Identified Care Coordinators at each primary care site will maintain a list of relevant community resources, including named care coordinators at other primary care locations. This list will be updated annually to assure accurate information. |
| Provider Type| N/A |
| Status       | In Progress |
| Start Date   | 04/01/2015 |
| End Date     | 03/31/2017 |
| Quarter      | DY2 Q4 |

| Task         | a.i. Phase 1 PCP Practices: Care coordinators are identified for each primary care site. |
| Provider Type| N/A |
| Status       | In Progress |
| Start Date   | 04/01/2015 |
| End Date     | 03/31/2017 |
| Quarter      | DY2 Q4 |

| Task         | a.ii. Phase 2 PCPs Practices: Care coordinators are identified for each primary care site. |
| Provider Type| N/A |
| Status       | In Progress |
| Start Date   | 04/01/2015 |
| End Date     | 03/31/2017 |
| Quarter      | DY2 Q4 |

<p>| Task         | a.iii. Phase 3 PCPs Practices: Care coordinators are identified for each primary care site. |
| Provider Type| N/A |
| Status       | In Progress |
| Start Date   | 04/01/2015 |
| End Date     | 03/31/2017 |
| Quarter      | DY2 Q4 |</p>
<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>established as well as inter-location coordination responsibilities</td>
<td>Provider</td>
<td></td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
</tr>
<tr>
<td>EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td>PPS uses alerts and secure messaging functionality.</td>
<td>Provider</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>a. Assess all participating PCPs to determine their preparedness for sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up</td>
<td>Provider</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<td>a.i. Phase 1 PCPs complete</td>
<td>Project</td>
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<td>12/31/2015</td>
<td>12/31/2015</td>
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<tr>
<td>a.ii. Phase 2 PCPs complete</td>
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<td>03/31/2016</td>
<td>03/31/2016</td>
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<tr>
<td>b. Perform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
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<tr>
<td>b.i. Phase 1 PCPs complete</td>
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## Samaritan Medical Center (PPS ID: 45)

### Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
**Task** b.ii. Phase 2 PCPs complete | Project | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
**Task** b.iii. Phase 3 PCPs complete | Project | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4
**Task** c. Create a project plan/timeline for each PCP | Project | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4
**Task** c. i. Phase 1 PCPs complete | Project | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
**Task** c. ii. Phase 2 PCPs complete | Project | In Progress | 04/01/2015 | 12/31/2015 | 12/31/2015 | DY1 Q3
**Task** c. iii. Phase 3 PCPs complete | Project | In Progress | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4
**Task** d. Implement the interoperability/interfaces. | Project | In Progress | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2
**Task** d. i. Phase 1 PCPs complete | Project | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4
**Task** d. ii. Phase 2 PCPs complete | Project | In Progress | 04/01/2015 | 06/30/2017 | 06/30/2017 | DY3 Q1
**Task** d. iii. Phase 3 PCPs complete | Project | In Progress | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2
**Task** e. i. Phase 1 PCPs: EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements. | Project | In Progress | 04/01/2015 | 06/30/2017 | 06/30/2017 | DY3 Q1
**Task** e. ii. Phase 2 PCPs: EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements. | Project | In Progress | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2
**Task** e. iii. Phase 3 PCPs: EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements. | Project | In Progress | 04/01/2015 | 12/31/2017 | 12/31/2017 | DY3 Q3
**Task** f. i. Phase 1 PCPs: PPS uses alerts and secure messaging functionality. | Project | In Progress | 04/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2
**Task** f. ii. Phase 2 PCPs: PPS uses alerts and secure messaging functionality. | Project | In Progress | 04/01/2015 | 12/31/2017 | 12/31/2017 | DY3 Q3
**Task** f. iii. Phase 3 PCPs: PPS uses alerts and secure messaging functionality. | Project | In Progress | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 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 | 04/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4
### Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Task</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<td><strong>Task</strong></td>
<td><strong>Provider</strong></td>
<td><strong>Status</strong></td>
<td><strong>Start Date</strong></td>
<td><strong>End Date</strong></td>
<td><strong>DY</strong></td>
<td><strong>Q</strong></td>
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<tr>
<td>PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM. Project</td>
<td>Safety Net Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td>a. Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH. Provider</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>b. Preform a gap analysis on the results to determine the scope of work/needed assistance for each PCP. Provider</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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</tr>
<tr>
<td>c. Create a project plan/timeline for each PCP Provider</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
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</tr>
<tr>
<td>d. Implement the Meaningful Use (MU) workflows &amp; discrete data documentation. Provider</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2017</td>
<td>09/30/2017</td>
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### Samaritan Medical Center (PPS ID:45)

**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**  
**Run Date:** 09/24/2015  
**NYS Confidentiality – High**
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

<table>
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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>Provider Type</th>
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<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
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<td>06/30/2017</td>
<td>06/30/2017</td>
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<tr>
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<td>Project</td>
<td>In Progress</td>
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<td>09/30/2017</td>
<td>09/30/2017</td>
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<td>Task e.iii. Phase 3 PCPs: EHR meets Meaningful Use Stage 2 CMS requirements</td>
<td>Project</td>
<td>In Progress</td>
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<td>12/31/2017</td>
<td>12/31/2017</td>
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<td>09/30/2017</td>
<td>09/30/2017</td>
<td>DY3 Q2</td>
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<td>Task f.ii. Phase 2 PCPs: PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2017</td>
<td>12/31/2017</td>
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<td>Task f.iii. Phase 3 PCPs: PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/30/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>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.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td>Task a. Connect all PCP's to the Regional Registry</td>
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<td>07/01/2015</td>
<td>12/31/2017</td>
<td>12/31/2017</td>
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<td>06/30/2017</td>
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<td>Task a. ii. Phase 2 PCPs complete</td>
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<tr>
<td>Task 1. Safety-Net providers will utilize current EHR reporting mechanisms to run at least annual reports of targeted populations needing care services.</td>
<td>Project</td>
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<td>03/31/2017</td>
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<tr>
<td>Task 2. Safety-Net providers will utilize said reports to perform patient outreach via EHR reminders, letters, and patient portal messaging systems.</td>
<td>Project</td>
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<tr>
<td>Milestone #7 Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.</td>
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NYS Confidentiality – High
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<th>Provider Type</th>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>Practice has adopted preventive and chronic care protocols aligned with national guidelines.</td>
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<tr>
<td>Task</td>
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<td>Primary Care Physicians</td>
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<td>04/01/2015</td>
<td>03/31/2020</td>
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<td>DY5 Q4</td>
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<td>Task</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
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<td>12/31/2017</td>
<td>12/31/2017</td>
<td>DY3 Q3</td>
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<tr>
<td>Task a. Each Primary Care Site within the PPS will complete NCQA standard 3E- Implementing Evidence-based preventive and chronic disease management.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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<td>09/30/2017</td>
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<td>DY3 Q2</td>
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<td>12/31/2017</td>
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<td>Task b.ii. Phase 2 PCPs: Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.</td>
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<td>Project</td>
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<td>12/31/2017</td>
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<td>DY3 Q3</td>
</tr>
<tr>
<td>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.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<td>Task</td>
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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID: 45)

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

<table>
<thead>
<tr>
<th>Protocols and processes for referral to appropriate services are in place.</th>
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<tr>
<td>a. Each Primary Care Site within the PPS will Complete the NCQA standard 3C</td>
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<td>03/31/2017</td>
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<td>Comprehensive Health Assessment which includes the use of a standardized</td>
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### Project Requirements

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<th>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.</th>
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<td>Task</td>
<td>b. Preform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
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<td>c. Create a project plan/timeline for each PCP</td>
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<td>d. Implement the PCMH processes, procedures, protocols and written policies.</td>
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<td>Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.</td>
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**NYS Confidentiality – High**
## Samaritan Medical Center (PPS ID: 45)

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<td>2. Identified Physician Champion representing each primary care practice will view educational PCMH 2014 webinar, and will attest to said viewing.</td>
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<td>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.</td>
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<td>2. Identified Care Coordinators at each primary care site will maintain a list of relevant community resources, including named care coordinators at other primary care locations. This list will be updated annually to assure accurate information.</td>
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<td>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</td>
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<td>PPS uses alerts and secure messaging functionality.</td>
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<td>a. Assess all participating PCPs to determine their preparedness for sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up</td>
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<td><strong>Task</strong> b. Preform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
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<td>Task e.iii. Phase 3 PCPs: EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<td>Task f. Phase 1 PCPs: PPS uses alerts and secure messaging functionality.</td>
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<td>Task f.ii. Phase 2 PCPs: PPS uses alerts and secure messaging functionality.</td>
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<td>Task f.iii. Phase 3 PCPs: PPS uses alerts and secure messaging functionality.</td>
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Milestone #5
Ensure that EHR systems used by participating safety net
Table: Project Requirements

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<th>Project Requirements (Milestone/Task Name)</th>
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<tr>
<td>providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.</td>
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<td>Task</td>
<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
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<td>Task</td>
<td>a. Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
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<td>Task</td>
<td>b. Perform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
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<td>Task</td>
<td>c. Create a project plan/timeline for each PCP</td>
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<td>Task</td>
<td>d. Implement the Meaningful Use (MU) workflows &amp; discrete data documentation.</td>
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NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

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<th>Task</th>
<th>DY1,Q1</th>
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<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
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<td>a. Connect all PCP's to the Regional Registry</td>
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<td>Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic care.</td>
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# Samaritan Medical Center (PPS ID: 45)

## Project Requirements (Milestone/Task Name)

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<td><strong>Task</strong> 3. <strong>Each Primary Care Site within the</strong></td>
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<td><strong>(PHQ-2 or 9 for those screening positive, SBIRT)</strong></td>
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**NYS Confidentiality – High**
### Project Requirements

**(Milestone/Task Name)**

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<tr>
<th>PCPs, including behavioral health screenings (PHQ-2 or 9, SBIRT).</th>
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<tbody>
<tr>
<td><strong>Task</strong> Protocols and processes for referral to appropriate services are in place.</td>
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<tr>
<td><strong>Task</strong> a. Each Primary Care Site within the PPS will Complete the NCQA standard 3C Comprehensive Health Assessment which includes the use of a standardized preventative screening tool for behavioral health for all patients. The PPS will create a process to assure referrals to the appropriate site. This process will be tracked with referral tracking within PCMH.</td>
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<tr>
<td><strong>Task</strong> a.i. Phase 1 PCPs complete</td>
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<tr>
<td><strong>Task</strong> a.ii. Phase 2 PCPs complete</td>
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<tr>
<td><strong>Task</strong> a.iii. Phase 3 PCPs complete</td>
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<tr>
<td><strong>Milestone #9</strong> Implement open access scheduling in all primary care practices.</td>
</tr>
<tr>
<td><strong>Task</strong> PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.</td>
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<tr>
<td><strong>Task</strong> PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.</td>
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<tr>
<td><strong>Task</strong> PPS monitors and decreases no-show rate by at least 15%.</td>
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<tr>
<td><strong>Task</strong> a. Each Primary Care Site within the PPS will complete the NCQA standard 1A Patient Centered Access including the offering of same day appointment access for same day appointments for both routine and urgent care needs. These use of these appointments will be monitored and re evaluated by the primary care site.</td>
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<td><strong>Task</strong> a. i. Phase 1 PCPs complete</td>
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<td><strong>Task</strong> a.ii. Phase 2 PCPs complete</td>
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<td><strong>Task</strong> a.iii. Phase 3 PCPs complete</td>
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<tr>
<td><strong>Task</strong> b.i Phase 1 PCPs: PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care</td>
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*NYS Confidentiality – High*
## Project Requirements (Milestone/Task Name)

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<th>DY5,Q3</th>
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<td>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.</td>
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### Project Requirements

#### (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4
---|---|---|---|---|---|---|---|---|---|---
**Task**

b.ii. Phase 2 PCPs complete

task b.ii. Phase 3 PCPs complete

c. Create a project plan/timeline for each PCP

task c.i. Phase 1 PCPs complete

task c.ii. Phase 2 PCPs complete

task c.iii. Phase 3 PCPs complete

d. Implement the PCMH processes, procedures, protocols and written policies.

task d.i. Phase 1 PCPs complete

task d.ii. Phase 2 PCPs complete

task d.iii. Phase 3 PCPs complete

e. Complete the NCQA Level 3 PCMH submissions

task e.i. Phase 1 PCPs complete

task e.ii. Phase 2 PCPs complete

task e.iii. Phase 3 PCPs complete

f. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates

task f.i. Phase 1 PCPs complete

task f.ii. Phase 2 PCPs complete

task f.iii. Phase 3 PCPs complete

**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

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### Project Requirements

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<td>Task 1. Identified Physician Champion representing each primary care practice will sign memorandum stating said role.</td>
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<td>Task 2. Identified Physician Champion representing each primary care practice will view educational PCMH 2014 webinar, and will attest to said viewing.</td>
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**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.

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<th>Task</th>
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<td>Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities.</td>
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<td>Clinical Interoperability System in place for all participating providers and document usage by the identified care coordinators.</td>
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<td>Task 2. Identified Care Coordinators at each primary care site will maintain a list of relevant community resources, including named care coordinators at other primary care locations. This list will be updated annually to assure accurate information.</td>
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<tr>
<td><strong>Task</strong> b.i. Phase 1 PCP Practices: Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities</td>
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<td><strong>Task</strong> c.ii. Phase 2 PCPs Practices complete: Clinical Interoperability System in place for all participating providers and documented usage by the identified care coordinators.</td>
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<tr>
<td><strong>Milestone #4</strong> 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.</td>
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<td><strong>Task</strong> PPS uses alerts and secure messaging functionality.</td>
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<td><strong>Task</strong> a. Assess all participating PCPs to determine their preparedness for sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

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NYS Confidentiality – High
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<td>Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.</td>
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<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
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<td>1. Safety-Net providers will utilize current EHR reporting mechanisms to run at least annual reports of targeted populations needing care services.</td>
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<td>2. Safety-Net providers will utilize said reports to perform patient outreach via EHR reminders, letters, and patient portal</td>
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NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

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<td>Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.</td>
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<td>Practice has adopted preventive and chronic care protocols aligned with national guidelines.</td>
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<tr>
<td>a. Each Primary Care Site within the PPS will complete NCQA standard 3E-Implementing Evidence-based guidelines for a mental health condition, a chronic medical condition, and acute condition, a condition related to unhealthy behavior, well child or adult care, and appropriateness use/overuse or overuse issues</td>
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<td>1. All staff members in each role at the Primary Care practice will view the educational PCMH 2014 webinar prior to initial PCMH Baseline Assessment and will attest to said viewing.</td>
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<td>b. i. Phase 1 PCPs: Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.</td>
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<td>b. iii. Phase 2 PCPs: Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.</td>
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<td>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.</td>
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NYS Confidentiality – High
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<td>process is developed for assuring referral to appropriate care in a timely manner.</td>
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<td>Task Preventive care screenings implemented among participating PCPs, including behavioral health screenings (PHQ-2 or 9, SBIRT).</td>
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<td>Task Protocols and processes for referral to appropriate services are in place.</td>
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<tr>
<td>Task a. Each Primary Care Site within the PPS will Complete the NCQA standard 3C Comprehensive Health Assessment which includes the use of a standardized preventative screening tool for behavioral health for all patients. The PPS will create a process to assure referrals to the appropriate site. This process will be tracked with referral tracking within PCMH.</td>
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<td>Milestone #9 Implement open access scheduling in all primary care practices.</td>
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<td>Task PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.</td>
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<td>Task PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.</td>
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<td>Task PPS monitors and decreases no-show rate by at least 15%.</td>
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<tr>
<td>Task a. Each Primary Care Site within the PPS will complete the NCQA standard 1A Patient Centered Access including the offering of same day appointment access for same day appointments for both routine and urgent care needs. These use of these appointments will be monitored and re evaluated by the primary care site.</td>
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--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
Task
  a.iii Phase 3 PCPs complete
Task
  b.i Phase 1 PCPs: PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.
Task
  b.ii Phase 2 PCPs: PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.
Task
  b.iii Phase 3 PCPs: PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.
Task
  c.i Phase 1 PCPs: PPS monitors and decreases no-show rate by at least 15%.
Task
  c.ii Phase 2 PCPs: PPS monitors and decreases no-show rate by at least 15%.
Task
  c.iii Phase 3 PCPs: PPS monitors and decreases no-show rate by at least 15%.

Prescribed Milestones Current File Uploads

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Prescribed Milestones Narrative Text

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<th>Milestone Name</th>
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<tr>
<td>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.</td>
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<tr>
<td>Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.</td>
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<td>Identify care coordinators at each primary care site</td>
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### Prescribed Milestones Narrative Text

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<th>Milestone Name</th>
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<tr>
<td>who are responsible for care connectivity, internally, as well as connectivity to care managers at other primary care practices.</td>
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<tr>
<td>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.</td>
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<tr>
<td>Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.</td>
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<tr>
<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.</td>
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<tr>
<td>Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.</td>
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<tr>
<td>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.</td>
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<tr>
<td>Implement open access scheduling in all primary care practices.</td>
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IPQR Module 2.a.ii.5 - PPS Defined Milestones

Instructions:

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

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<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
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IPQR Module 2.a.ii.6 - IA Monitoring

Instructions:
Project 2.a.iv – Create a medical village using existing hospital infrastructure

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

Instructions:

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

1) Risk: NCI Service region is already operationally lean and geographically large with multiple Critical Access Hospitals. In the DSRIP application, it was noted that while the region needed the Medical Village capability of integrated services there was only an expected 6-8 bed reduction due to the lean environment. With the expected additional service utilization through engagement of additional UI, LU and NU and additional Primary Care/Prevention utilization it is possible that bed utilization could temporarily grow through new identified critical issues.
   Mitigation: Continue to critically analyze data to ensure capacity is right-sized to meet need – thus reducing specific bed capacity in a very targeted manner while maintaining ability of the region to retain essential capacity to meet population need.

2) Risk: Financially fragile hospital partners will fail prior to ability to change operations through medical village
   Mitigation: Support financially fragile partners to develop financial sustainability plans in concert with VAPAP

3) Risk: Medical villages will be developed and underutilized
   Mitigation: Ensure that medical villages are supported by CNA and community to be served through data analysis and community forums

4) Risk: EHR and PCMH implementations within Medical Villages will not be complete/successful
   Mitigation: Comprehensive assessment and gap analysis will ensure that a successful implementation plan is carried out so that all PCMH submissions by providers serving Medical Villages are successful

5) Risk: Telemedical solutions are not embraced by community and/or providers
   Mitigation: Aggressive education of providers. Public education campaign to engage public. Inclusion of telemedicine discussion in public forums. Telemedical physician champions are identified within medical villages utilizing telemedicine.
IPQR Module 2.a.iv.2 - Project Implementation Speed

Instructions:

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

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

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<th>Year, Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Expected Number of Medical Villages Established</th>
<th>Total Committed Providers</th>
<th>Percent Committed Providers (%)</th>
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<th>Expected Number of Medical Villages Established</th>
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NYS Confidentiality – High
IPQR Module 2.a.iv.3 - Patient Engagement Speed

Instructions:

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

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
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<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>500</td>
<td>750</td>
<td>1,000</td>
<td>1,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Percent of Expected Engagement(%)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>10.00</td>
<td>15.00</td>
<td>20.00</td>
<td>20.00</td>
<td>40.00</td>
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<table>
<thead>
<tr>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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<tr>
<td>Patients Engaged</td>
<td>3,500</td>
<td>5,000</td>
<td>1,250</td>
<td>2,500</td>
<td>3,750</td>
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<tr>
<td>Percent of Expected Engagement(%)</td>
<td>70.00</td>
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Current File Uploads

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Narrative Text:
### Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone #1 Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> A strategic plan is in place which includes, at a minimum:</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>- Definition of services to be provided in medical village and justification based on CNA</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>- Plan for transition of inpatient capacity</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>- Description of process to engage community stakeholders</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>- Description of any required capital improvements and physical location of the medical village</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>- Plan for marketing and promotion of the medical village and consumer education regarding access to medical village services</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Project must reflect community involvement in the development and the specific activities that will be undertaken during the project term.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 1. Perform a gap analysis to accurately determine current inpatient bed capacity / bed constraints across the PPS (determine optimal inpatient delivery model)</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 2. Establish a Service Utilization monitoring team made up of an assigned lead from each impacted hospital to provide oversight in measuring, evaluating, and recommending excess bed reductions to the NCI Governing Board. (determine the number beds that can be reduced vs. percent of staffed beds)</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong> 3. Each participating hospital facility will develop a strategic plan that outlines: medical village services, inpatient capacity transition plan, stakeholder engagement processes, capital improvement requirements, geographical location of medical village, marketing and consumer education and community involvement.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td>Task</td>
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<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
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<td>07/01/2015</td>
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<td>09/30/2016</td>
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<td>09/30/2016</td>
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<td>6.</td>
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<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<td>7.</td>
<td>Project</td>
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<td>07/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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<td>8.</td>
<td>Project</td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td>9.</td>
<td>Project</td>
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<td>In Progress</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<td>09/30/2016</td>
<td>09/30/2016</td>
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<td>2.</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY3 Q4</td>
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</tbody>
</table>

Milestone #2
Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.

Task 1. Develop a PPS master plan the specifies bed reductions, facilities affected, and rationale for bed reductions

Task 2. Utilize gap analysis to develop strategic timeline for bed reductions: focusing on low impact / low population facilities first

Task 3. Detail bed reduction transition timeline

Task 4. Realign and Redesign timeline as required to improve transition of care

Milestone #3
Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH

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

**Samaritan Medical Center (PPS ID:45)**

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Task</strong> All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
<td>DY1 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> 2. Perform a gap analysis and a plan with budget to address the identified needs.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 3. Perform a pre-PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to apply for NCQA PCMH by DSRIP DY3.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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<tr>
<td><strong>Task</strong> 4. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
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<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 5. During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, &amp; issues are communicated and a plan is in place to address them.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Milestone #4</strong> Ensure that all safety net providers participating in Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Non-PCP Practitioners</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Hospitals</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Behavioral Health</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
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**NYS Confidentiality – High**
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tr>
<td>1. Conduct an assessment of the current practices and clinics to</td>
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<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<td>determine the needed infrastructure, training and implementation</td>
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<td>required to ensure all providers are fully utilizing EHRs to</td>
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<td>provide coordinated care across the PPS.</td>
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</tr>
<tr>
<td>2. Perform a gap analysis and a plan with budget to address the</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2015</td>
<td>12/31/2015</td>
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<td>identified needs.</td>
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<td>3. Begin implementations with prioritization based on attributed</td>
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<td>03/31/2016</td>
<td>DY1 Q4</td>
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<td>Medicaid population and provider engagement.</td>
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<td>4. During the implementation phase and all phases that follow,</td>
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<td>prepare a report to the governance committee to ensure that all</td>
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<td>risks &amp; issues are communicated and a plan is in place to address</td>
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<td>them.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Perform a post-go-live gap analysis and a plan with budget to</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
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<td>03/31/2017</td>
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<td>address the identified needs.</td>
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<td>6. Facilitate the practice's connection with the HealtheConnections</td>
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<td>RHIO and the regional PHM platform to ensure they have access to</td>
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<td>all information the patient has consented to in order to provide</td>
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<tr>
<td>efficient, effective and high-quality care.</td>
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<td>DY2 Q4</td>
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<tr>
<td>Use EHRs and other technical platforms to track all patients</td>
<td>Project</td>
<td></td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>1. Identify targeted patient population through data collection</td>
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<td>2. Integrate clinical decision support functions based on</td>
<td>Project</td>
<td></td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>evidence-based guidelines into EHR (i.e., order sets, alerts).</td>
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NYS Confidentiality – High
**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**  

**Samaritan Medical Center (PPS ID:45)**

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<tr>
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<th>Quarter End Date</th>
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<tr>
<td>5. Routinely Measure outcomes through quality assessment</td>
<td>Project</td>
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<td><strong>Milestone #6</strong></td>
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<td>2. Perform a post-go-live gap analysis and a plan with budget to address the identified needs.</td>
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<td>3. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
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<td>03/31/2016</td>
<td>DY1 Q4</td>
<td>4. Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</td>
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<td><strong>Task</strong></td>
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<td>DY3 Q4</td>
<td>5. Begin MU attestations with prioritization based on attributed Medicaid population and provider engagement.</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
<td><strong>Milestone #7</strong> Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.</td>
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<td><strong>Task</strong></td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
<td>Strategy developed for migration of any services to different setting or location (clinic, hospitals, etc.).</td>
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<td>Project</td>
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<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
<td>1. Utilize the comprehensive community needs assessment that demonstrates and documents the needs of the PPSs targeted population with service area updates in the strategic plan.</td>
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<tr>
<td><strong>Task</strong></td>
<td>Project</td>
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<td>09/30/2016</td>
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<td>DY2 Q2</td>
<td>2. Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</td>
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NYS Confidentiality – High
### Project Requirements

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<tr>
<td>2. Ensure that individual and PPS wide medical village strategic plans that migrate services to a different location/setting include utilization of community needs assessment to develop a migration plan.</td>
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<td>In Progress</td>
<td>04/01/2015</td>
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<td>DY2 Q4</td>
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<td>Task 3. Develop policy/procedure for periodic updates to CNA and service area mapping.</td>
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<td>03/31/2017</td>
<td>DY2 Q4</td>
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#### Project Requirements

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<thead>
<tr>
<th>Milestone #1</th>
<th>Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.</th>
</tr>
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<tbody>
<tr>
<td>Task</td>
<td>A strategic plan is in place which includes, at a minimum: - Definition of services to be provided in medical village and justification based on CNA. - Plan for transition of inpatient capacity. - Description of process to engage community stakeholders. - Description of any required capital improvements and physical location of the medical village. - Plan for marketing and promotion of the medical village and consumer education regarding access to medical village services.</td>
</tr>
<tr>
<td>Task</td>
<td>Project must reflect community involvement in the development and the specific activities that will be undertaken during the project term.</td>
</tr>
<tr>
<td>Task</td>
<td>1. Perform a gap analysis to accurately determine current inpatient bed capacity / bed constraints across the PPS. (determine optimal inpatient delivery model).</td>
</tr>
<tr>
<td>Task</td>
<td>2. Establish a Service Utilization monitoring team made up of an assigned lead from each impacted hospital to provide oversight in measuring, evaluating, and recommending excess bed reductions to the NCI Governing Board. (determine the number beds that can be reduced vs. percent of staffed beds).</td>
</tr>
<tr>
<td>Task</td>
<td>3. Each participating hospital facility will develop a strategic plan that outlines: medical village services, inpatient capacity.</td>
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</tbody>
</table>
### New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

**Samaritan Medical Center (PPS ID:45)**

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<tr>
<td>transition plan, stakeholder engagement processes, capital improvement requirements, geographical location of medical village, marketing and consumer education and community involvement.</td>
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<tr>
<td>Task 4. The NCI PPS collaboratively compiles a strategic plan that outlines: medical village services, inpatient capacity transition plan, stakeholder engagement processes, capital improvement requirements, geographical locations of medical villages, marketing and consumer education and community involvement.</td>
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<td>Task 5. Each plan will detail community involvement: requirements / roles and responsibilities that will be completed during the project lifecycle</td>
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<td>Task 6. Approval of Individual Strategic Plans by individual hospital boards</td>
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<td>Task 7. Approval of Individual Strategic Plans by NCI Governing Board</td>
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<tr>
<td>Task 8. Approval of NCI PPS collaborative Medical Village Strategic Plan by NCI Governing Board</td>
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<td>Task 9. Implementation of Individual Plans at each facility progress via reports tracked bi-monthly for task completion and inclusion in NCI PPS Medical Village plan reporting including community involvement.</td>
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**Milestone #2**

Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.

**Task**

PPS has bed reduction timeline and implementation plan in place with achievable targeted reduction in "staffed" beds.

**Task**

1. Develop a PPS master plan the specific bed reductions, facilities affected, and rationale for bed reductions
2. Utilize gap analysis to develop strategic timeline for bed reductions; focusing on low impact / low population facilities first
3. Detail bed reduction transition timeline

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<td>Task 4. Realign and Redesign timeline as required to improve transition of care</td>
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<td>Milestone #3 Ensure that all participating PCPs 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.</td>
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<td>Task 3. Perform a pre-PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to apply for NCQA PCMH by DSRIP DY3.</td>
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<td>Task 6. Begin PCMH recognitions with prioritization based on attributed Medicaid population and provider engagement.</td>
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<tr>
<td><strong>Milestone #4</strong> Ensure that all safety net providers participating in Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.</td>
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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID: 45)

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#### Milestone #5

Use EHRs and other technical platforms to track all patients engaged in the project.

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<tbody>
<tr>
<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<tbody>
<tr>
<td>1. Identify targeted patient population through data collection</td>
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<td>2. Integrate clinical decision support functions based on evidence-based guidelines into EHR (i.e., order sets, alerts).</td>
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<td>Task Strategy developed for migration of any services to different setting or location (clinic, hospitals, etc.).</td>
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</table>
**Project Requirements (Milestone/Task Name)**

<table>
<thead>
<tr>
<th>Population with service area updates in the strategic plan</th>
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</thead>
</table>
| Task
| 2. Ensure that individual and PPS wide medical village strategic plans that migrate services to a different location/setting include utilization of community needs assessment to develop a migration plan |
| Task
| 3. Develop policy/procedure for periodic updates to CNA and service area mapping |

<table>
<thead>
<tr>
<th>Milestone #1</th>
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</thead>
<tbody>
<tr>
<td>Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.</td>
</tr>
</tbody>
</table>
| Task
| A strategic plan is in place which includes, at a minimum:
| - Definition of services to be provided in medical village and justification based on CNA
| - Plan for transition of inpatient capacity
| - Description of process to engage community stakeholders
| - Description of any required capital improvements and physical location of the medical village
| - Plan for marketing and promotion of the medical village and consumer education regarding access to medical village services |
| Task
| Project must reflect community involvement in the development and the specific activities that will be undertaken during the project term. |
| Task
| 1. Perform a gap analysis to accurately determine current inpatient bed capacity / bed constraints across the PPS (determine optimal inpatient delivery model) |
| Task
| 2. Establish a Service Utilization monitoring team made up of an assigned lead from each impacted hospital to provide oversight in measuring, evaluating, and recommending excess bed reductions to the NCI Governing Board. (determine the number beds that can be reduced vs. percent of staffed beds) |
| Task
| 3. Each participating hospital facility will develop a strategic
<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
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<tr>
<td>plan that outlines: medical village services, inpatient capacity transition plan, stakeholder engagement processes, capital improvement requirements, geographical location of medical village, marketing and consumer education and community involvement.</td>
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<tr>
<td>Task 4. The NCI PPS collaboratively compiles a strategic plan that outlines: medical village services, inpatient capacity transition plan, stakeholder engagement processes, capital improvement requirements, geographical locations of medical villages, marketing and consumer education and community involvement.</td>
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<td>Task 5. Each plan will detail community involvement: requirements / roles and responsibilities that will be completed during the project lifecycle</td>
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<td>Task 6. Approval of Individual Strategic Plans by individual hospital boards</td>
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<td>Task 7. Approval of Individual Strategic Plans by NCI Governing Board</td>
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<tr>
<td>Task 8. Approval of NCI PPS collaborative Medical Village Strategic Plan by NCI Governing Board</td>
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<tr>
<td>Task 9. Implementation of Individual Plans at each facility progress via reports tracked bi-monthly for task completion and inclusion in NCI PPS Medical Village plan reporting including community involvement</td>
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</table>

**Milestone #2**

Provide a detailed timeline documenting the specifics of bed reduction and rationale. Specified bed reduction proposed in the project must include active or "staffed" beds.

**Task**

PPS has bed reduction timeline and implementation plan in place with achievable targeted reduction in "staffed" beds.

**Task**

1. Develop a PPS master plan that specifies bed reductions, facilities affected, and rationale for bed reductions

**Task**

2. Utilize gap analysis to develop strategic timeline for bed reductions: focusing on low impact / low population facilities first

**Task**

3. Detail bed reduction transition timeline
# DSRIP Implementation Plan Project

## Samaritan Medical Center (PPS ID:45)

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<thead>
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<th>DY5,Q4</th>
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</thead>
<tbody>
<tr>
<td><strong>Task</strong> 4. Realign and Redesign timeline as required to improve transition of care</td>
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<tr>
<td><strong>Task</strong> 3. Perform a pre-PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to apply for NCQA PCMH by DSRIP DY3.</td>
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<td><strong>Task</strong> 5. During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, &amp; issues are communicated and a plan is in place to address them.</td>
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<td><strong>Task</strong> 6. Begin PCMH recognitions with prioritization based on attributed Medicaid population and provider engagement.</td>
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<td><strong>Task</strong> EHR meets connectivity to RHIO’s HIE and SHIN-NY requirements.</td>
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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID: 45)

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<td>Use EHRs and other technical platforms to track all patients engaged in the project.</td>
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<tr>
<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td>Task 1. Identify targeted patient population through data collection</td>
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<td>Task 2. Integrate clinical decision support functions based on evidence-based guidelines into EHR (i.e., order sets, alerts).</td>
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NYS Confidentiality – High
## Project Requirements

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<tr>
<td>3. Track / Monitor actively engaged patients utilizing designated tracking systems</td>
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<td>4. Report actively engaged patients against milestone completion</td>
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<td>5. Routinely Measure outcomes through quality assessment</td>
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**Milestone #6**

Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2

**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**

1. Perform a pre-MU assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating in order to attest for MU DSRIP DY3.

2. Perform a post-go-live gap analysis and a plan with budget to address the identified needs.

**Task**

3. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.

4. Facilitate the practice’s connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.

5. Begin MU attestations with prioritization based on attributed Medicaid population and provider engagement.

**Milestone #7**

Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are supported by the comprehensive community needs assessment.

**Task**

Strategy developed for migration of any services to different setting or location (clinic, hospitals, etc.).

**Task**

1. Utilize the comprehensive community needs assessment that demonstrates and documents the needs of the PPSs targeted.
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#### Task

2. Ensure that individual and PPS wide medical village strategic plans that migrate services to a different location/setting include utilization of community needs assessment to develop a migration plan

3. Develop policy/procedure for periodic updates to CNA and service area mapping

### Prescribed Milestones Current File Uploads

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

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### IPQR Module 2.a.iv.5 - PPS Defined Milestones

**Instructions:**

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

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<th>Status</th>
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<th>End Date</th>
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### PPS Defined Milestones Current File Uploads

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<th>Description</th>
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### PPS Defined Milestones Narrative Text

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

Samaritan Medical Center (PPS ID:45)

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

Instructions:
Project 2.b.iv – Care transitions intervention model to reduce 30 day readmissions for chronic health conditions

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

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

1. Risk: Federal HPSA designation, thus resulting in barriers to access to care, the lack of an assigned provider, or the inability to receive a timely appointment
   Mitigation:
   a) Grow primary care capacity through the workforce strategy
   b) Back up providers so clinicians can operate at the top of their license
   c) Integrate behavioral health and primary care
   d) Use telehealth (telemedicine and remote monitoring) to expand access to care and help patients feel connected to care

2. Risk: Median household income is at least $10,000 less than the state average (14-18% below the poverty level) and on average, 10% are unemployed
   Mitigation:
   a) Identify supportive services for patients prior to discharge (i.e. health home, community-based organizations) to help address the lack of housing, transportation, or the means to pay a co-pay

3. Risk: Health Literacy and Cultural Competency
   Mitigation:
   a) Health literacy and cultural competency training for providers
   b) Incorporation of the teach-back method and motivational interviewing

4. Risk: Varied, or lack of standardized roles, responsibilities, protocols, policies and procedures related to care coordination/care transitions depending on the time, place or provider
   a) Development of clearly defined roles and responsibilities (i.e. care coordinator, care transition manager, community health worker, patient navigator, etc.)
   b) Development and adoption of standardized protocols, policies and procedures

5. Risk: Willingness of partners to adopt standardized protocols, policies and procedures
   Mitigation:
   a) Engage hospitals, behavioral health agencies, private practices, the health home, FQHC's, long-term care facilities, etc. in multi-level governance structure that not only facilitates buy-in, but informs the process.

6. Risk: Lack of reimbursement/a payment strategy for the transition of care services
   Mitigation:
a) Engage with Medicaid Managed Care plans to develop payment agreements
b) Increase referrals and utilization of the Health Home

7. Risk: Systematic Record Transition Process
a) Increase utilization of E-Discharge for long-term care providers
b) Ensure medical record is updated in interoperable EHR or updated in primary care provider record
**IPQR Module 2.b.iv.2 - Project Implementation Speed**

Instructions:

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year, Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year, Quarter (DY3,Q3 – DY5,Q4)</th>
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<td>DY1,Q2</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>Non-PCP Practitioners</td>
<td>264</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Hospitals</td>
<td>6</td>
<td>0</td>
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<tr>
<td>Health Home / Care Management</td>
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<td>0</td>
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<tr>
<td>Community Based Organizations</td>
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<td>All Other</td>
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<tr>
<td>Total Committed Providers</td>
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<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year, Quarter (DY3,Q3 – DY5,Q4)</th>
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<td>DY3,Q3</td>
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<tr>
<td>Primary Care Physicians</td>
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<td>Non-PCP Practitioners</td>
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<td>Hospitals</td>
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<td>Community Based Organizations</td>
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<td>All Other</td>
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<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>497</td>
<td>0</td>
</tr>
</tbody>
</table>

Percent Committed Providers (%)

|                                              |                  | 0.00   | 0.00   | 0.00   | 0.00   | 0.00   | 0.00   | 0.00   | 0.00   | 0.00   | 0.00   | 0.00   |

NYS Confidentiality – High
Samaritan Medical Center (PPS ID:45)

Current File Uploads

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<th>User ID</th>
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No Records Found

Narrative Text:

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

Samaritan Medical Center (PPS ID:45)

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

Instructions:

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

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

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
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<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>320</td>
<td>480</td>
<td>640</td>
<td>1,600</td>
<td>3,200</td>
<td>3,840</td>
<td>4,480</td>
<td>1,600</td>
<td>3,200</td>
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<td>Percent of Expected Engagement</td>
<td>0.00</td>
<td>5.00</td>
<td>7.50</td>
<td>10.00</td>
<td>25.00</td>
<td>50.00</td>
<td>60.00</td>
<td>70.00</td>
<td>25.00</td>
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<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<th>DY3,Q4</th>
<th>DY4,Q1</th>
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<th>DY5,Q3</th>
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<tr>
<td>Patients Engaged</td>
<td>4,800</td>
<td>6,400</td>
<td>1,600</td>
<td>3,200</td>
<td>4,800</td>
<td>6,400</td>
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<tr>
<td>Percent of Expected Engagement</td>
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<td>25.00</td>
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Narrative Text:
### IPQR Module 2.b.iv.4 - Prescribed Milestones

Instructions:

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

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<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>Milestone #1</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task 1. Ensure standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task 2. Establish Regional Care Transitions Committee with a defined charter and ongoing agendas and minutes</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td>Task 3. Establish cross functional teams that span the delivery system including hospitals, long-term care, the health home, hospice, and community-based organizations that integrate existing social/community support services, behavioral health agencies, chemical dependency programs, and the expansion of remote monitoring services to enhance patient support.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td>Task 4. Document process and workflow including responsible resources at each stage of the workflow, minimum data sets required at each transition of care and the method of information transmission at each stage of the workflow</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task 5. Develop assessment and risk stratification tools to be used at hospital admissions and ED visits to target beneficiaries for care coordination (including medical, behavioral and social risks).</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td>Task 6. Ensure early notification of discharges for warm handoff and health record transfer across the care continuum utilizing the RHIO to ensure communication of patient records to receiving community providers</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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<tr>
<td>Project Requirements (Milestone/Task Name)</td>
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<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIUP Reporting Year and Quarter</td>
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<tr>
<td>7. Documentation of training materials to demonstrate consistent and ongoing efforts related to care coordination</td>
<td></td>
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</tr>
<tr>
<td><strong>Milestone #2</strong> Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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</tr>
<tr>
<td><strong>Task</strong> PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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</tr>
<tr>
<td><strong>Task</strong> 1. Establish agreements with Managed Care Organizations and Health Homes related to coordination of services for high risk populations, including those with mental illness, cardiovascular disease, COPD, diabetes and substance abuse</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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</tr>
<tr>
<td><strong>Task</strong> 2. Ensure a payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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</tr>
<tr>
<td><strong>Task</strong> 3. Coordinate care transition strategies including focused referrals and increased utilization of MCO and Health Home services</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td><strong>Task</strong> 4. Document methods and strategies including identification of responsible resources at each stage of the workflow including the identification of health concerns and social disparities before discharge, thus providing continuity of care to enable future early intervention</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 5. Conduct periodic assessments and produce updates that provide feedback mechanism and monitor progress</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 6. Secure evidence of agreements related to coordination of care transition strategies with Health Homes to ensure patients are identified in the acute care setting and referred to the Health Home based on the presence of one or more chronic condition or one single qualifying condition of either HIV/AIDS or Serious Mental Illness.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
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</tr>
<tr>
<td>7. Ensure PPS Protocols and processes in place to identify Health Home eligible patients and link them to services as required under ACA, thus addressing both clinical and social determinants of health that are highly correlated with admissions or readmissions.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
<td></td>
</tr>
<tr>
<td>8. Train staff on protocols/processes, and include written documentation of materials and sign in sheets</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #3</strong> Ensure required social services participate in the project.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Task</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>1. Increase awareness of and leverage social service agencies such as the two FQHCs, the St. Lawrence Psych Mobile Integration Team, the Health Home, the Children’s Home Crisis Intervention Team, Social Services, the Volunteer Transportation Center and medically tailored home food services in the care transition process.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>2. Generate a list of support services that will help facilitate the transition of care from the hospital to home or community residence, and from the home to primary care, thus ensuring services are provided at the right time, in the right place and in the most cost effective way.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
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</tr>
<tr>
<td>3. Engage community supportive services through meeting participation, panel presentations, electronic distribution of materials, etc.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
</tr>
<tr>
<td>4. Document process and workflow including responsible resources at each stage of the workflow to ensure that patients are effectively, safely, and optimally transitioning to, and remaining in outpatient care, thus reducing the incidence of hospital or ED use</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/30/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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</tr>
<tr>
<td>5. Documented evidence of agreements with social support services to ensure factors related to non-adherence to discharge regimens are addressed (i.e. health literacy, language issues, lack of engagement with community health care system, etc.)</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
<td></td>
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<tr>
<td>6. Conduct routine assessments and produce periodic reports with updates to</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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### Samaritan Medical Center (PPS ID:45)

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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>demonstrate collaborative progress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #4</strong> Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Policies and procedures are in place for early notification of planned discharges.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td><strong>Task</strong> Policies and procedures are in place for early notification of planned discharges.</td>
<td>Provider</td>
<td>Non-PCP Practitioners</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td><strong>Task</strong> Policies and procedures are in place for early notification of planned discharges.</td>
<td>Provider</td>
<td>Hospitals</td>
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<td>04/01/2015</td>
<td>03/31/2020</td>
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<td>DY5 Q4</td>
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<tr>
<td><strong>Task</strong> PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 1. Ensure policies and procedures are in place for early notification of planned discharges for warm hand off and health record transfer across the care continuum utilizing the RHIO</td>
<td>Project</td>
<td></td>
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<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
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<tr>
<td><strong>Task</strong> 2. Document early notification of planned discharge process and workflow including responsible resources at each stage to demonstrate navigation, coordination and transitional care management</td>
<td>Project</td>
<td></td>
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<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 3. Document written training materials including list of training dates and number of staff trained</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/30/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 4. Facilitate the transition of care from hospital to home or community residence, and from the home to primary care by allowing case managers access to visit the patients in the he hospital and provide education and advocacy through the support and self-management of chronic conditions.</td>
<td>Project</td>
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<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 5. Document agreement between hospital and care management staff/agencies allowing them access to visit patients upon admissions and/or prior to discharge, in accordance with standardized protocols and processes.</td>
<td>Project</td>
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<td>04/01/2015</td>
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<td>09/30/2016</td>
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<tr>
<td><strong>Task</strong> 6. Generate documentation from vendor systems to support training efforts and</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/30/2017</td>
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NYS Confidentiality – High
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<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocols will include care record transitions with timely updates provided to the members’ providers, particularly primary care provider.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>1. Leverage and expand the use of electronic health records and the Population Health Management System to assure that patients with chronic diseases are receiving appropriate care and preventive care.</td>
<td>Project</td>
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<td>04/01/2015</td>
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<td>DY2 Q3</td>
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<tr>
<td>2. Ensure care transition policies and procedures are incorporated into an updated patient medical record and then transferred to receiving community providers including primary care providers.</td>
<td>Project</td>
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<td>DY2 Q3</td>
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<tr>
<td>3. Document care record transition process and workflow including responsible resources at each stage to ensure smooth and effective navigation, coordination and transitional care management while facilitating integration or re-integration with primary care and outpatient mental health services thus reducing the rate of hospitalization, readmissions and ED use</td>
<td>Project</td>
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<td>In Progress</td>
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<td>DY2 Q4</td>
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<tr>
<td>4. Document written training materials including list of training dates and number of staff trained</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
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<td>5. Conduct periodic self-audit reports and recommendations to ensure engagement and inform, improve and sustain two-way communication with patients and providers</td>
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<tr>
<td>Ensure that a 30-day transition of care period is established.</td>
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<tr>
<td>2. Adopt strategies and implement policies and procedures that reflect the standardized 30-day transition of care period protocols.</td>
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<td>04/01/2015</td>
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<td>DY2 Q3</td>
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<tr>
<td><strong>Task 3.</strong> Adopt improvement processes and plans that address top health disparities and improve workflow of the interdisciplinary team to include standardized protocols, assessment and risk stratification, early notification of discharges for warm handoff, health record transfer across the care continuum, self-management programs (i.e. remote monitoring), as well as patient education (teach back method) and advocacy.</td>
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<td>In Progress</td>
<td>04/01/2015</td>
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<td><strong>Task 4.</strong> Documentation of policies, procedures and protocols</td>
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<tr>
<td><strong>Milestone #7</strong> Use EHRs and other technical platforms to track all patients engaged in the project.</td>
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<td>03/31/2017</td>
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<td>DY2 Q4</td>
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<tr>
<td><strong>Task</strong> PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td></td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
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<td>DY2 Q4</td>
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<tr>
<td><strong>Task 1.</strong> Leveraging our technological infrastructure, ensure that providers in the PPS can work efficiently and effectively across the integrated delivery system to provide a seamless transition by and between systems ensure the best patient outcomes.</td>
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<td><strong>Task 2.</strong> Assess, stratify and identify targeted patients and track actively engaged patients for project milestone reporting.</td>
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<td>04/01/2015</td>
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<tr>
<td><strong>Task 3.</strong> Provide sample data collection and tracking system to ensure the target population is clearly identified for monitoring and care based on risk stratification to include medical, behavioral and social risks.</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
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<td>DY2 Q4</td>
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<tr>
<td><strong>Task 4.</strong> Provide reports from patient centered records to track implementation, progress and outcomes related to project 2biv</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
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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 | Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community | | | | | | | | | |
### Project Requirements

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
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<tbody>
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<td>Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.</td>
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<tr>
<td>Task 2. Establish Regional Care Transitions Committee with a defined charter and ongoing agendas and minutes</td>
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<tr>
<td>Task 3. Establish cross functional teams that span the delivery system including hospitals, long-term care, the health home, hospice, and community-based organizations that integrate existing social/community support services, behavioral health agencies, chemical dependency programs, and the expansion of remote monitoring services to enhance patient support.</td>
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<tr>
<td>Task 4. Document process and workflow including responsible resources at each stage of the workflow, minimum data sets required at each transition of care and the method of information transmission at each stage of the workflow</td>
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<tr>
<td>Task 5. Develop assessment and risk stratification tools to be used at hospital admissions and ED visits to target beneficiaries for care coordination (including medical, behavioral and social risks).</td>
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<tr>
<td>Task 6. Ensure early notification of discharges for warm handoff and health record transfer across the care continuum utilizing the RHIO to ensure communication of patient records to receiving community providers</td>
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<tr>
<td>Task 7. Documentation of training materials to demonstrate consistent and ongoing efforts related to care coordination</td>
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<tr>
<td>Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.</td>
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<tr>
<td>Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and</td>
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<td>Project Requirements (Milestone/Task Name)</td>
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<tr>
<td>Health Homes.</td>
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<tr>
<td><strong>Task</strong> Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.</td>
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<tr>
<td><strong>Task</strong> PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.</td>
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<tr>
<td>1. Establish agreements with Managed Care Organizations and Health Homes related to coordination of services for high risk populations, including those with mental illness, cardiovascular disease, COPD, diabetes and substance abuse</td>
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<tr>
<td><strong>Task</strong> Ensure a payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.</td>
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<tr>
<td>2. Coordinate care transition strategies including focused referrals and increased utilization of MCO and Health Home services</td>
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<tr>
<td><strong>Task</strong> Document methods and strategies including identification of responsible resources at each stage of the workflow including the identification of health concerns and social disparities before discharge, thus providing continuity of care to enable future early intervention</td>
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<tr>
<td><strong>Task</strong> Conduct periodic assessments and produce updates that provide feedback mechanism and monitor progress</td>
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<tr>
<td><strong>Task</strong> Secure evidence of agreements related to coordination of care transition strategies with Health Homes to ensure patients are identified in the acute care setting and referred to the Health Home based on the presence of one or more chronic condition or one single qualifying condition of either HIV/AIDS or Serious Mental Illness.</td>
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<tr>
<td><strong>Task</strong> Ensure PPS Protocols and processes in place to identify Health Home eligible patients and link them to services as required under ACA, thus addressing both clinical and social determinants of health that are highly correlated with admissions or readmissions.</td>
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*NYS Confidentiality – High*
### Task
8. Train staff on protocols/processes, and include written documentation of materials and sign in sheets

**Milestone #3**
Ensure required social services participate in the project.

**Task**
Required network social services, including medically tailored home food services, are provided in care transitions.

**Task**
1. Increase awareness of and leverage social service agencies such as the two FQHCs, the St. Lawrence Psych Mobile Integration Team, the Health Home, the Children's Home Crisis Intervention Team, Social Services, the Volunteer Transportation Center and medically tailored home food services in the care transition process.

**Task**
2. Generate a list of support services that will help facilitate the transition of care from the hospital to home or community residence, and from the home to primary care, thus ensuring services are provided at the right time, in the right place and in the most cost effective way.

**Task**
3. Engage community supportive services through meeting participation, panel presentations, electronic distribution of materials, etc.

**Task**
4. Document process and workflow including responsible resources at each stage of the workflow to ensure that patients are effectively, safely, and optimally transitioning to, and remaining in outpatient care, thus reducing the incidence of hospital or ED use.

**Task**
5. Documented evidence of agreements with social support services to ensure factors related to non-adherence to discharge regimens are addressed (i.e. health literacy, language issues, lack of engagement with community health care system, etc.)

**Task**
6. Conduct routine assessments and produce periodic reports with updates to demonstrate collaborative progress.

**Milestone #4**
Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.
### Project Requirements

<table>
<thead>
<tr>
<th>Task</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
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<td>PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.</td>
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<td>Facilitate the transition of care from hospital to home or community residence, and from the home to primary care by allowing case managers access to visit the patients in the hospital and provide education and advocacy through the support and self-management of chronic conditions.</td>
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<td>Document agreement between hospital and care management staff/agencies allowing them access to visit patients upon admissions and/or prior to discharge, in accordance with standardized protocols and processes.</td>
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<td>Generate documentation from vendor systems to support training efforts and outcomes</td>
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<td>Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.</td>
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<td>Policies and procedures are in place for including care</td>
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**Milestone #5**

- Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.

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**NYS Confidentiality – High**
### Samaritan Medical Center (PPS ID: 45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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</thead>
<tbody>
<tr>
<td>transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.</td>
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<tr>
<td>Task 1. Leverage and expand the use of electronic health records and the Population Health Management System to assure that patients with chronic diseases are receiving appropriate care and preventive care.</td>
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<tr>
<td>Task 2. Ensure care transition policies and procedures are incorporated into an updated patient medical record and then transferred to receiving community providers including primary care providers.</td>
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<td>Task 3. Document care record transition process and workflow including responsible resources at each stage to ensure smooth and effective navigation, coordination and transitional care management while facilitating integration or re-integration with primary care and outpatient mental health services thus reducing the rate of hospitalization, readmissions and ED use.</td>
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<td>Task 4. Document written training materials including list of training dates and number of staff trained.</td>
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<td>Task 5. Conduct periodic self-audit reports and recommendations to ensure engagement and inform, improve and sustain two-way communication with patients and providers.</td>
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<td>Milestone 6: Ensure that a 30-day transition of care period is established.</td>
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<td>Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.</td>
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<td>Task 1. Ensure interdisciplinary care coordination teams are formed including nursing staff, pharmacists, dieticians, community health workers, health home care managers, physicians, etc.</td>
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<td>Task 2. Adopt strategies and implement policies and procedures that reflect the standardized 30-day transition of care period protocols.</td>
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<td>Task 3. Adopt improvement processes and plans that address top health disparities and improve workflow of the interdisciplinary team to include standardized protocols, assessment and risk stratification, early notification of discharges for warm handoff.</td>
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### Project Requirements

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<tr>
<td>health record transfer across the care continuum, self-management programs (i.e. remote monitoring), as well as patient education (teach back method) and advocacy.</td>
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<td>Task 4. Documentation of policies, procedures and protocols</td>
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<td><strong>Milestone #7</strong></td>
<td>Use EHRs and other technical platforms to track all patients engaged in the project.</td>
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<td>Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<tr>
<td>Task 1. Leveraging our technological infrastructure, ensure that providers in the PPS can work efficiently and effectively across the integrated delivery system to provide a seamless transition by and between systems ensure the best patient outcomes.</td>
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<td>Task 2. Assess, stratify and identify targeted patients and track actively engaged patients for project milestone reporting.</td>
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<td>Task 3. Provide sample data collection and tracking system to ensure the target population is clearly identified for monitoring and care based on risk stratification to include medical, behavioral and social risks.</td>
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<td>Task 4. Provide reports from patient centered records to track implementation, progress and outcomes related to project 2biv</td>
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| Milestone #1 | Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency. | | | | | | | | | |
| Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place. | | | | | | | | | |
| Task 1. Ensure standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place. | | | | | | | | | |

NYS Confidentiality – High
### Project Requirements

#### (Milestone/Task Name)

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<th>Project Requirements</th>
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<tr>
<td>2. Establish Regional Care Transitions Committee with a defined charter and ongoing agendas and minutes</td>
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<td>3. Establish cross functional teams that span the delivery system including hospitals, long-term care, the health home, hospice, and community-based organizations that integrate existing social/community support services, behavioral health agencies, chemical dependency programs, and the expansion of remote monitoring services to enhance patient support.</td>
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<td>4. Document process and workflow including responsible resources at each stage of the workflow, minimum data sets required at each transition of care and the method of information transmission at each stage of the workflow</td>
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<td>5. Develop assessment and risk stratification tools to be used at hospital admissions and ED visits to target beneficiaries for care coordination (including medical, behavioral and social risks).</td>
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<td>6. Ensure early notification of discharges for warm handoff and health record transfer across the care continuum utilizing the RHIO to ensure communication of patient records to receiving community providers</td>
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<td>7. Documentation of training materials to demonstrate consistent and ongoing efforts related to care coordination</td>
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<td>Milestone #2 ENGAGE WITH THE MEDICAID MANAGED CARE ORGANIZATIONS AND HEALTH HOMES TO DEVELOP TRANSITION OF CARE PROTOCOLS THAT WILL ENSURE APPROPRIATE POST-DISCHARGE PROTOCOLS ARE FOLLOWED</td>
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<td>A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.</td>
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<td>Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.</td>
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<td>PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.</td>
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<td>1. Establish agreements with Managed Care Organizations and</td>
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NYS Confidentiality – High
## Project Requirements

### (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Health Homes related to coordination of services for high risk populations, including those with mental illness, cardiovascular disease, COPD, diabetes and substance abuse</th>
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<tbody>
<tr>
<td>Task 2. Ensure a payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.</td>
</tr>
<tr>
<td>Task 3. Coordinate care transition strategies including focused referrals and increased utilization of MCO and Health Home services</td>
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<tr>
<td>Task 4. Document methods and strategies including identification of responsible resources at each stage of the workflow including the identification of health concerns and social disparities before discharge, thus providing continuity of care to enable future early intervention</td>
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<tr>
<td>Task 5. Conduct periodic assessments and produce updates that provide feedback mechanism and monitor progress</td>
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<tr>
<td>Task 6. Secure evidence of agreements related to coordination of care transition strategies with Health Homes to ensure patients are identified in the acute care setting and referred to the Health Home based on the presence of one or more chronic condition or one single qualifying condition of either HIV/AIDS or Serious Mental Illness.</td>
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<tr>
<td>Task 7. Ensure PPS Protocols and processes in place to identify Health Home eligible patients and link them to services as required under ACA, thus addressing both clinical and social determinants of health that are highly correlated with admissions or readmissions.</td>
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<tr>
<td>Task 8. Train staff on protocols/processes, and include written documentation of materials and sign in sheets</td>
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</table>

### Milestone #3

- Ensure required social services participate in the project.

### Task

- Required network social services, including medically tailored home food services, are provided in care transitions.

### Task 1

- Increase awareness of and leverage social service agencies such as the two FQHCs, the St. Lawrence Psych Mobile Integration Team, the Health Home, the Children's Home Crisis...
## Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Project Requirement</th>
<th>DY3,Q3</th>
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<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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<tbody>
<tr>
<td><strong>Task 1.</strong> Generate a list of support services that will help facilitate the transition of care from the hospital to home or community residence, and from the home to primary care, thus ensuring services are provided at the right time, in the right place and in the most cost effective way.</td>
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<td><strong>Task 2.</strong> Integrate community supportive services through meeting participation, panel presentations, electronic distribution of materials, etc.</td>
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<td><strong>Task 3.</strong> Document process and workflow including responsible resources at each stage of the workflow to ensure that patients are effectively, safely, and optimally transitioning to, and remaining in outpatient care, thus reducing the incidence of hospital or ED use</td>
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<td><strong>Task 4.</strong> Document evidence of agreements with social support services to ensure factors related to non-adherence to discharge regiments are addressed (i.e. health literacy, language issues, lack of engagement with community health care system, etc.)</td>
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<td><strong>Task 5.</strong> Conduct routine assessments and produce periodic reports with updates to demonstrate collaborative progress</td>
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**Milestone #4**

Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.

<p>| Task 1. Policies and procedures are in place for early notification of planned discharges. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Task 2. Policies and procedures are in place for early notification of planned discharges. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Task 3. Policies and procedures are in place for early notification of planned discharges. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Task 4. PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services | | | | | | | | | | |</p>
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<th>Project Requirements (Milestone/Task Name)</th>
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<td>1. Ensure policies and procedures are in place for early notification of planned discharges for warm hand off and health record transfer across the care continuum utilizing the RHIO</td>
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<td>2. Document early notification of planned discharge process and workflow including responsible resources at each stage to demonstrate navigation, coordination and transitional care management</td>
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<tr>
<td>3. Document written training materials including list of training dates and number of staff trained</td>
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<td>4. Facilitate the transition of care from hospital to home or community residence, and from the home to primary care by allowing case managers access to visit the patients in the hospital and provide education and advocacy through the support and self-management of chronic conditions.</td>
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<tr>
<td>5. Document agreement between hospital and care management staff/agencies allowing them access to visit patients upon admissions and/or prior to discharge, in accordance with standardized protocols and processes.</td>
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<td>6. Generate documentation from vendor systems to support training efforts and outcomes</td>
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<td><strong>Milestone #5</strong></td>
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<tr>
<td>Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.</td>
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<tr>
<td>Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.</td>
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<tr>
<td>1. Leverage and expand the use of electronic health records and the Population Health Management System to assure that patients with chronic diseases are receiving appropriate care and preventive care.</td>
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<tr>
<td>2. Ensure care transition policies and procedures are incorporated into an updated patient medical record and then</td>
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</table>
transferred to receiving community providers including primary care providers.

Task 3. Document care record transition process and workflow including responsible resources at each stage to ensure smooth and effective navigation, coordination and transitional care management while facilitating integration or re-integration with primary care and outpatient mental health services thus reducing the rate of hospitalization, readmissions and ED use.

Task 4. Document written training materials including list of training dates and number of staff trained.

Task 5. Conduct periodic self-audit reports and recommendations to ensure engagement and inform, improve and sustain two-way communication with patients and providers.

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

Task 1. Ensure interdisciplinary care coordination teams are formed including nursing staff, pharmacists, dieticians, community health workers, health home care managers, physicians, etc.

Task 2. Adopt strategies and implement policies and procedures that reflect the standardized 30-day transition of care period protocols.

Task 3. Adopt improvement processes and plans that address top health disparities and improve workflow of the interdisciplinary team to include standardized protocols, assessment and risk stratification, early notification of discharges for warm handoff, health record transfer across the care continuum, self-management programs (i.e. remote monitoring), as well as patient education (teach back method) and advocacy.

Task 4. Documentation of policies, procedures and protocols.

**Milestone #7**
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.
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

### Project Requirements

<table>
<thead>
<tr>
<th>Task</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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<tr>
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#### Prescribed Milestones Current File Uploads

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#### Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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</thead>
<tbody>
<tr>
<td>Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.</td>
<td></td>
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<tr>
<td>Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.</td>
<td></td>
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<tr>
<td>Ensure required social services participate in the project.</td>
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<tr>
<td>Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.</td>
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</table>

NYS Confidentiality – High
Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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</thead>
<tbody>
<tr>
<td>Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.</td>
<td></td>
</tr>
<tr>
<td>Ensure that a 30-day transition of care period is established.</td>
<td></td>
</tr>
<tr>
<td>Use EHRs and other technical platforms to track all patients engaged in the project.</td>
<td></td>
</tr>
</tbody>
</table>
### IPQR Module 2.b.iv.5 - PPS Defined Milestones

**Instructions:**

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

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

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### PPS Defined Milestones Narrative Text

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

Instructions:

[Blank space]
Project 2.d.i – Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care

☑ IPQR Module 2.d.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.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The current system is fragmented, severely impacting the lives of those with significant burden of disease. In addition to a lack of linkages between inpatient and outpatient services, there are also disconnects between CBOs and primary care (PC), between preventive services and PC, and between PC and mental health and alcohol and substance abuse.</td>
<td>The PPS anticipates that by developing an integrated delivery system and by integrating behavioral health and primary care, the region will benefit from reduced system fragmentation.</td>
</tr>
<tr>
<td>Many individuals that are at high risk have families and caregivers that want to help, however, the system is so complex and disconnected that families cannot effectively navigate it.</td>
<td>Community Health Workers/Navigators will be trained and deployed in hot spots to ensure patient activation, education, and connectivity to resources.</td>
</tr>
<tr>
<td>The most significant immediate need when addressing preventive care for the Medicaid and UI population will be to grow the PC, dental and behavioral health licensed health professional workforce. The NCI region has been federally designated a low-income Medicaid Health Professional Shortage Area (HPSA) and we cannot connect people to PC that does not exist.</td>
<td>The NCI workforce strategy will recruit, train and incentivize PCPs to serve our region, specifically the Medicaid population.</td>
</tr>
<tr>
<td>14% of our population lacks basic literacy skills. The regional illiteracy rates coupled with the fact that NCI residents are older and have lower income levels than NYS highlight the need to improve health literacy in our region, as low literacy is linked to poor health outcomes, higher rates of hospitalizations, and infrequent use of preventive services.</td>
<td>The NCI will formally train on the PAM and regularly update assessments of communities and individual patients to ensure we are engaging and providing quality healthcare to the population. We will also train providers located within hot spots on techniques such as shared decision making, measurements of health literacy, and cultural competency.</td>
</tr>
</tbody>
</table>
### IPQR Module 2.d.i.2 - Project Implementation Speed

**Instructions:**

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

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td>PAM(R) Providers</td>
<td>60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent Committed Providers (%)</td>
<td>0.00</td>
<td>0.00</td>
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<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<tr>
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<td>DY3,Q3</td>
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<tr>
<td>PAM(R) Providers</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>60</td>
<td>0</td>
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<tr>
<td>Percent Committed Providers (%)</td>
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**Narrative Text:**

NYS Confidentiality – High
**IPQR Module 2.d.i.3 - Patient Engagement Speed**

**Instructions:**

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

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

### Benchmarks

<table>
<thead>
<tr>
<th>100% Actively Engaged By</th>
<th>Expected Patient Engagement</th>
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<tr>
<td>DY3,Q4</td>
<td>4,000</td>
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<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
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<th>DY1,Q2</th>
<th>DY1,Q3</th>
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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>550</td>
<td>1,100</td>
<td>1,650</td>
<td>2,200</td>
<td>1,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>2.50</td>
<td>13.75</td>
<td>27.50</td>
<td>41.25</td>
<td>55.00</td>
<td>25.00</td>
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<thead>
<tr>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
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<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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<tbody>
<tr>
<td>Patients Engaged</td>
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<td>4,000</td>
<td>1,000</td>
<td>2,000</td>
<td>3,000</td>
<td>4,000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>75.00</td>
<td>100.00</td>
<td>25.00</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
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**Narrative Text:**

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

Samaritan Medical Center (PPS ID:45)

**IPQR Module 2.d.i.4 - Prescribed Milestones**

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

<table>
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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong> Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Partnerships with CBOs to assist in patient &quot;hot-spotting&quot; and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 1. Identify CBO's in PPS's geographical area that can engage target populations.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 2. Establish linkages with CBO's in the PPS's geographical targeted population areas</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 3. Develop engagement plan that outlines numbers of CBO's required, service requirements and alignment of CBO’s specific roles and responsibilities in achieving DSRIP deliverables pertaining to PAM</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 4. Partner with and contract CBO's to target population through PAM utilization.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong> 5. Implement and utilize communications engagement plan to: inform, improve, sustain two-way communications.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 6. NCI provides oversight and ensures sufficient engagement, quality measures and quarterly reporting.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Milestone #2</strong> Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Patient Activation Measure(R) (PAM(R)) training team established.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
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## Project Requirements

### Task

1. Determine ideal agencies and stakeholders to serve as PPS-wide PAM coaches  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2016  
   - Quarter End Date: 03/31/2016  
   - DSRIP Reporting Year and Quarter: DY1 Q4

2. Identify and train one master PAM coach for the entire PPS  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 06/30/2016  
   - Quarter End Date: 06/30/2016  
   - DSRIP Reporting Year and Quarter: DY2 Q1

3. Train PPS-wide training team (PAM coaches) via Insignia Train-the-Trainer sessions  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 06/30/2016  
   - Quarter End Date: 06/30/2016  
   - DSRIP Reporting Year and Quarter: DY2 Q1

4. Document names, roles, agencies, and location of PAM coaches  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2017  
   - Quarter End Date: 03/31/2017  
   - DSRIP Reporting Year and Quarter: DY2 Q4

5. Archive copies of training materials, sign-in sheets and other documentation  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2017  
   - Quarter End Date: 03/31/2017  
   - DSRIP Reporting Year and Quarter: DY2 Q4

### Milestone #3

Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.  
   - Status: Project N/A  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2017  
   - Quarter End Date: 03/31/2017  
   - DSRIP Reporting Year and Quarter: DY2 Q4

### Task

1. Using PQI, Census and other DSRIP health data at the zip code level, identify "hot spot" areas and develop a map delineating regions with large populations of UI, NU and LU  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2017  
   - Quarter End Date: 03/31/2017  
   - DSRIP Reporting Year and Quarter: DY2 Q4

2. Work with CBOs to develop outreach lists for UI, NU, LU populations and identify outreach strategy in "hot spots"  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2017  
   - Quarter End Date: 03/31/2017  
   - DSRIP Reporting Year and Quarter: DY2 Q4

### Milestone #4

Survey the targeted population about healthcare needs in the PPS' region.  
   - Status: Project N/A  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2017  
   - Quarter End Date: 03/31/2017  
   - DSRIP Reporting Year and Quarter: DY2 Q4

### Task

1. Community engagement forums and other information-gathering mechanisms established and performed.  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2017  
   - Quarter End Date: 03/31/2017  
   - DSRIP Reporting Year and Quarter: DY2 Q4

2. a. Develop data collection instrument to gather feedback on healthcare needs in the region  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2017  
   - Quarter End Date: 03/31/2017  
   - DSRIP Reporting Year and Quarter: DY2 Q4

3. b. Organize community forums to gather information from residents about healthcare needs in region  
   - Reporting Level: Project  
   - Provider Type: In Progress  
   - Status: In Progress  
   - Start Date: 04/01/2015  
   - End Date: 03/31/2017  
   - Quarter End Date: 03/31/2017  
   - DSRIP Reporting Year and Quarter: DY2 Q4

### Milestone #5

Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.  
   - Status: Project N/A  
   - Start Date: 07/01/2015  
   - End Date: 03/31/2018  
   - Quarter End Date: 03/31/2018  
   - DSRIP Reporting Year and Quarter: DY3 Q4

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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<tbody>
<tr>
<td>PPS Providers (located in &quot;hot spot&quot; areas) trained in patient activation techniques by &quot;PAM(R) trainers&quot;.</td>
<td>Project</td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
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<tr>
<td><strong>Task</strong></td>
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<tr>
<td>a. Identify providers in &quot;hot spot&quot; areas</td>
<td>Project</td>
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<td>07/01/2015</td>
<td>03/31/2017</td>
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<tr>
<td>b. Deploy training team to conduct PAM training with PPS providers in &quot;hot spot&quot; areas</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<td><strong>Milestone #6</strong></td>
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<tr>
<td>Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member’s MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).</td>
<td>Project</td>
<td>N/A</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>• This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.</td>
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</tr>
<tr>
<td>• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.</td>
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<tr>
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<tr>
<td>Procedures and protocols established to allow the PPS to work with the member’s MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.</td>
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<tr>
<td>a. Obtain lists of PCPs assigned to NU and LU enrollees from Managed Care Organizations</td>
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<tr>
<td>b. Work with MCOs, PCPs and Community Health Workers to reconnect beneficiaries to designated PCPs</td>
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<tr>
<td>Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.</td>
<td>Project</td>
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<td>In Progress</td>
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<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
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<tr>
<td>For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).</td>
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<tr>
<td>Task a. Develop timeline for PAM assessments (baseline, periodic, annual)</td>
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<td>03/31/2016</td>
<td>03/31/2016</td>
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<tr>
<td>Task b. Work with CBOs to conduct baseline and periodic PAM assessment for each cohort of beneficiaries</td>
<td>Project</td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td>Task c. Analyze data to create a baseline measure for each year's cohort</td>
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<td>03/31/2018</td>
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<td>Task d. Use Flourish portal to assess project implementation and outreach</td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
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<tr>
<td>Include beneficiaries in development team to promote preventive care.</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>a. Identify patient members to participate in program development and awareness efforts</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>b. Recruit patient members to development team</td>
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<td>c. Establish meeting logistics and goals</td>
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<td>DY3 Q4</td>
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<tr>
<td>Measure PAM(R) components, including:</td>
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<tr>
<td>• Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or “hot spot” area for health service.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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</tr>
<tr>
<td>• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS’ network, assess patient using PAM(R) survey and designate a PAM(R) score.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td>• Individual member’s score must be averaged to calculate a baseline measure for that year’s cohort.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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</tr>
<tr>
<td>• The cohort must be followed for the entirety of the DSRIP program.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>• On an annual basis, assess individual members’ and each cohort’s level of engagement, with the goal of moving beneficiaries to a higher level of activation.</td>
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<tr>
<td>• If the beneficiary is deemed to be LU &amp; NU but has a designated PCP who is not part of the PPS’ network, counsel the beneficiary</td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU &amp; LU populations) on a monthly basis, as well as to DOH on a quarterly basis.</td>
<td>Project</td>
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<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Task 1. Identify and contract with Community Health Workers</td>
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<td>03/31/2016</td>
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<tr>
<td>Task 2. Train CHWs in connectivity to healthcare coverage, community healthcare resources and patient education</td>
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<td>DY1 Q4</td>
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<td>Task 3. Train CHWs to conduct PAM survey</td>
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<tr>
<td>Task 4. Ensure CHWs conduct direct hand-off to navigators and/or the appropriate level of care</td>
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<td>Task 5. Develop ability to track co-hort</td>
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<td>Task 6. Develop process to provide MCO most recent contact information</td>
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<tr>
<td>Task 7. Develop process to provide member engagement lists to insurance monthly and DOH quarterly</td>
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## Samaritan Medical Center (PPS ID:45)

### Project Requirements

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<td>Volume of non-emergent visits for UI, NU, and LU populations increased.</td>
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<tr>
<td>1. Work with PCPs, dental health providers, behavioral health providers and MCOs to identify strategies to expand access to care for UI, NU and LU populations</td>
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<tr>
<td>2. Work with PCPs, dental health providers, behavioral health providers and MCOs to implement strategies to expand access to care for UI, NU and LU populations</td>
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<tr>
<td>Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.</td>
<td>Project</td>
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<td>Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.</td>
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<tr>
<td>Task 2. Work with PCPs, dental health providers, behavioral health providers and MCOs to implement strategies to expand access to care for UI, NU and LU populations</td>
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<td>Task Community navigators identified and contracted.</td>
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<td>PAM(R) Providers</td>
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<tr>
<td>Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.</td>
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<td>Task 1. Contract with CBOs for community navigator services, specific to insurance and connection to primary and community-based care</td>
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<td>Task 2. Provide training, as needed, to community navigators to ensure seamless connectivity to preferred services (primary and preventive care)</td>
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<td>Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.</td>
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<td>Task Policies and procedures for customer service complaints and appeals developed.</td>
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<td>Task 2. Implement policies and procedure for customer service complaints and appeals</td>
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NYS Confidentiality – High
## Samaritan Medical Center (PPS ID: 45)

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<td>3. Review complaints and appeals to determine process and quality improvement opportunities</td>
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<td>Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).</td>
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<td>List of community navigators formally trained in the PAM(R).</td>
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<td>1. Identify and contract with community navigators</td>
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<td>2. Train navigators in connectivity to healthcare coverage, community healthcare resources and patient education</td>
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<td>3. Train navigators to conduct PAM survey</td>
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<td>4. Ensure navigators conduct direct hand-off to the appropriate level of care</td>
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<tr>
<td>Ensure direct hand-offs to navigators who are prominently placed at “hot spots,” partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.</td>
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<td>Community navigators prominently placed (with high visibility) at appropriate locations within identified “hot spot” areas.</td>
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<td>1. Develop protocol for hand-offs to identified navigators</td>
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<td>Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.</td>
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<td>Navigators educated about insurance options and healthcare resources available to populations in this project.</td>
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<td>1. Include navigator education in workforce education plan</td>
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<td>2. Include information channel for navigators in NCI DSRIP Communication Plan</td>
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### Samaritan Medical Center (PPS ID:45)

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<tr>
<td>Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.</td>
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<td>Timely access for navigator when connecting members to services.</td>
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<tr>
<td>1. Work with Med Management Committee to identify Safety Net Providers with access for each hot spot</td>
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<td>2. Develop protocol with access standard for navigators to access services target population</td>
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<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.</td>
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<td>PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.</td>
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<td>a. Identify target patients using patient registries</td>
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<td>b. Track actively engaged patients for reporting</td>
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<tbody>
<tr>
<td><strong>Milestone #1</strong> Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.</td>
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<tr>
<td><strong>Task</strong> Partnerships with CBOs to assist in patient “hot-spotting” and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.</td>
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<tr>
<td><strong>Task</strong> 1. Identify CBO’s in PPS’s geographical area that can engage target populations.</td>
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<td><strong>Task</strong> 2. Establish linkages with CBO’s in the PPS’s geographical targeted population areas</td>
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<td><strong>Task</strong> 3. Develop engagement plan that outlines numbers of CBO’s</td>
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### Samaritan Medical Center (PPS ID: 45)

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<tr>
<td>required, service requirements and alignment of CBO’s specific roles and responsibilities in achieving DSRIP deliverables pertaining to PAM</td>
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<td><strong>Task</strong> 4. Partner with and contract CBO’s to target population through PAM utilization.</td>
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<td><strong>Task</strong> 5. Implement and utilize communications engagement plan to: inform, improve, sustain two-way communications.</td>
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<tr>
<td>Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.</td>
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<tr>
<td><strong>Task</strong> Patient Activation Measure(R) (PAM(R)) training team established.</td>
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<tr>
<td><strong>Task</strong> 1. Determine ideal agencies and stakeholders to serve as PPS-wide PAM coaches</td>
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<tr>
<td><strong>Task</strong> 3. Train PPS-wide training team (PAM coaches) via Insignia Train-the-Trainer sessions</td>
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<td><strong>Task</strong> 4. Document names, roles, agencies, and location of PAM coaches</td>
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<td><strong>Task</strong> 5. Archive copies of training materials, sign-in sheets and other documentation</td>
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<tr>
<td>Identify UI, NU, and LU &quot;hot spot&quot; areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified &quot;hot spot&quot; areas.</td>
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<td><strong>Task</strong> Analysis to identify &quot;hot spot&quot; areas completed and CBOs performing outreach engaged.</td>
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<tr>
<td><strong>Task</strong> 1. Using PQI, Census and other DSRIP health data at the zip code level, identify &quot;hot spot&quot; areas and develop a map delineating regions with large populations of UI, NU and LU</td>
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### Project Requirements

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<tr>
<td>2. Work with CBOs to develop outreach lists for UI, NU, LU populations and identify outreach strategy in “hot spots”</td>
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<td>Milestone #4 Survey the targeted population about healthcare needs in the PPS’ region.</td>
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<td>Community engagement forums and other information-gathering mechanisms established and performed.</td>
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<td>a. Develop data collection instrument to gather feedback on healthcare needs in the region</td>
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<td>b. Organize community forums to gather information from residents about healthcare needs in region</td>
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<tr>
<td>Milestone #5 Train providers located in “hot spots” on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency</td>
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<td>PPS Providers (located in “hot spot” areas) trained in patient activation techniques by “PAM(R) trainers”.</td>
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<td>a. Identify providers in “hot spot” areas</td>
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<td>b. Deploy training team to conduct PAM training with PPS providers in “hot spot” areas</td>
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<td>Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member’s MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).</td>
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<td>• This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.</td>
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<td>• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.</td>
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<td>Procedures and protocols established to allow the PPS to work</td>
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### Project Requirements

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<td>with the member’s MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.</td>
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<tr>
<td>a. Obtain lists of PCPs assigned to NU and LU enrollees from Managed Care Organizations</td>
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<td>b. Work with MCOs, PCPs and Community Health Workers to reconnect beneficiaries to designated PCPs</td>
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| **Milestone #7**
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period. |        |        |        |        |        |        |        |        |        |        |
| a. Develop timeline for PAM assessments (baseline, periodic, annual) |        |        |        |        |        |        |        |        |        |        |
| b. Work with CBOs to conduct baseline and periodic PAM assessment for each cohort of beneficiaries |        |        |        |        |        |        |        |        |        |        |
| c. Analyze data to create a baseline measure for each year’s cohort |        |        |        |        |        |        |        |        |        |        |
| d. Use Flourish portal to assess project implementation and outreach |        |        |        |        |        |        |        |        |        |        |
| **Milestone #8**
Include beneficiaries in development team to promote preventive care. |        |        |        |        |        |        |        |        |        |        |
| a. Identify patient members to participate in program development and awareness efforts of preventive care services |        |        |        |        |        |        |        |        |        |        |
| b. Recruit patient members to development team |        |        |        |        |        |        |        |        |        |        |
| c. Establish meeting logistics and goals |        |        |        |        |        |        |        |        |        |        |
| **Milestone #9**
Measure PAM(R) components, including: |        |        |        |        |        |        |        |        |        |        |

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

Samaritan Medical Center (PPS ID:45)

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<th>Project Requirements (Milestone/Task Name)</th>
<th>DY1,Q1</th>
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<tbody>
<tr>
<td>• Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or &quot;hot spot&quot; area for health service.</td>
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<td>• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS’ network, assess patient using PAM(R) survey and designate a PAM(R) score.</td>
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<td>• Individual member’s score must be averaged to calculate a baseline measure for that year’s cohort.</td>
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<td>• The cohort must be followed for the entirety of the DSRIP program.</td>
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<td>• On an annual basis, assess individual members’ and each cohort’s level of engagement, with the goal of moving beneficiaries to a higher level of activation.</td>
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<td>• If the beneficiary is deemed to be LU &amp; NU but has a designated PCP who is not part of the PPS’ network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.</td>
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<td>• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.</td>
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<td>• PPS will be responsible for providing the most current contact information to the beneficiary’s MCO for outreach purposes.</td>
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<td>• Provide member engagement lists to relevant insurance companies (for NU &amp; LU populations) on a monthly basis, as well as to DOH on a quarterly basis.</td>
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Task
Performance measurement reports established, including but not limited to:
- Number of patients screened, by engagement level
- Number of clinicians trained in PAM(R) survey implementation
- Number of patient: PCP bridges established
- Number of patients identified, linked by MCOs to which they are associated
- Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis
- Member engagement lists to DOH (for NU & LU populations) on a monthly basis
- Annual report assessing individual member and the overall cohort’s level of engagement

Task
1. Identify and contract with Community Health Workers

Task
2. Train CHWs in connectivity to healthcare coverage, community healthcare resources and patient education
### Project Requirements

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<tr>
<th>Milestone/Task Name</th>
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<tr>
<td><strong>Task</strong> 3. Train CHWs to conduct PAM survey</td>
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<td><strong>Task</strong> 4. Ensure CHWs conduct direct hand-off to navigators and/or the appropriate level of care</td>
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<td><strong>Task</strong> 5. Develop ability to track co-hort</td>
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<td><strong>Task</strong> 6. Develop process to provide MCO most recent contact information</td>
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<td><strong>Task</strong> 7. Develop process to provide member engagement lists to insurance monthly and DOH quarterly</td>
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**Milestone #10**

Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.

- **Task** Volume of non-emergent visits for UI, NU, and LU populations increased.

**Milestone #11**

Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.

- **Task** Community navigators identified and contracted.
- **Task** Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.

**Task** 1. Work with PCPs, dental health providers, behavioral health providers and MCOs to identify strategies to expand access to care for UI, NU and LU populations

**Task** 2. Work with PCPs, dental health providers, behavioral health providers and MCOs to implement strategies to expand access to care for UI, NU and LU populations

**Task** Contract with CBOs for community navigator services, specific to insurance and connection to primary and community-based care

**Task** Provide training, as needed, to community navigators to ensure seamless connectivity to preferred services (primary

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NYS Confidentiality – High
# Project Requirements

## (Milestone/Task Name)

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### Milestone #12

Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.

**Task**

Policies and procedures for customer service complaints and appeals developed.

**Task**

1. Develop policies and procedures for customer service complaints and appeals

2. Implement policies and procedure for customer service complaints and appeals

3. Review complaints and appeals to determine process and quality improvement opportunities

### Milestone #13

Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).

**Task**

List of community navigators formally trained in the PAM(R).

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1. Identify and contract with community navigators

2. Train navigators in connectivity to healthcare coverage, community healthcare resources and patient education

3. Train navigators to conduct PAM survey

4. Ensure navigators conduct direct hand-off to the appropriate level of care

### Milestone #14

Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.

**Task**

Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.

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1. Develop protocol for hand-offs to identified navigators

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**Project Requirements**

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<td>Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.</td>
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<td>Navigators educated about insurance options and healthcare resources available to populations in this project.</td>
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<td>Task 1. Include navigator education in workforce education plan</td>
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<td>Task 2. Include information channel for navigators in NCI DSRIP Communication Plan</td>
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<td>Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.</td>
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<td>Timely access for navigator when connecting members to services.</td>
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<td>Task 1. Work with Med Management Committee to identify Safety Net Providers with access for each hot spot</td>
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<td>Task 2. Develop protocol with access standard for navigators to access services target population</td>
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<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.</td>
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<td>PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.</td>
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<td>Task a. Identify target patients using patient registries</td>
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<td>Task b. Track actively engaged patients for reporting</td>
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**Project Requirements**

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<td>Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.</td>
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<td>Partnerships with CBOs to assist in patient &quot;hot-spotting&quot; and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.</td>
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<tr>
<td><strong>Task</strong> 1. Identify CBO's in PPS's geographical area that can engage target populations.</td>
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<td><strong>Task</strong> 2. Establish linkages with CBO's in the PPS's geographical targeted population areas</td>
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<td><strong>Task</strong> 3. Develop engagement plan that outlines numbers of CBO's required, service requirements and alignment of CBO’s specific roles and responsibilities in achieving DSRIP deliverables pertaining to PAM</td>
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<td><strong>Task</strong> 4. Partner with and contract CBO's to target population through PAM utilization.</td>
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<td><strong>Task</strong> 5. Implement and utilize communications engagement plan to: inform, improve, sustain two-way communications.</td>
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<td><strong>Task</strong> 6. NCI provides oversight and ensures sufficient engagement, quality measures and quarterly reporting.</td>
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<td><strong>Milestone #2</strong> Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.</td>
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<td><strong>Task</strong> Patient Activation Measure(R) (PAM(R)) training team established.</td>
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<td><strong>Task</strong> 1. Determine ideal agencies and stakeholders to serve as PPS-wide PAM coaches</td>
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<td><strong>Task</strong> 2. Identify and train one master PAM coach for the entire PPS</td>
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<td><strong>Task</strong> 3. Train PPS-wide training team (PAM coaches) via Insignia Train-the-Trainer sessions</td>
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<td><strong>Task</strong> 4. Document names, roles, agencies, and location of PAM coaches</td>
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<td><strong>Task</strong> 5. Archive copies of training materials, sign-in sheets and other documentation</td>
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<td>Identify UI, NU, and LU &quot;hot spot&quot; areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified &quot;hot spot&quot; areas.</td>
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<td>Analysis to identify &quot;hot spot&quot; areas completed and CBOs performing outreach engaged.</td>
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<td>1. Using PQI, Census and other DSRIP health data at the zip code level, identify &quot;hot spot&quot; areas and develop a map delineating regions with large populations of UI, NU and LU</td>
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<td>2. Work with CBOs to develop outreach lists for UI, NU, LU populations and identify outreach strategy in &quot;hot spots&quot;</td>
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<td>Survey the targeted population about healthcare needs in the PPS' region.</td>
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<td>Community engagement forums and other information-gathering mechanisms established and performed.</td>
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<tr>
<td>a. Develop data collection instrument to gather feedback on healthcare needs in the region</td>
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<td>b. Organize community forums to gather information from residents about healthcare needs in region</td>
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<td>Train providers located within &quot;hot spots&quot; on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.</td>
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<td>PPS Providers (located in &quot;hot spot&quot; areas) trained in patient activation techniques by &quot;PAM(R) trainers&quot;.</td>
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<td>a. Identify providers in &quot;hot spot&quot; areas</td>
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<td>b. Deploy training team to conduct PAM training with PPS providers in &quot;hot spot&quot; areas</td>
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<td>Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).</td>
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<td>a. This patient activation project should not be used as a mechanism to inappropriately move members to different health</td>
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- plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member.
- Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.

**Task**

Procedures and protocols established to allow the PPS to work with the member’s MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.

**Task**

a. Obtain lists of PCPs assigned to NU and LU enrollees from Managed Care Organizations

**Task**

b. Work with MCOs, PCPs and Community Health Workers to reconnect beneficiaries to designated PCPs

**Milestone #7**

Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.

**Task**

For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).

**Task**

a. Develop timeline for PAM assessments (baseline, periodic, annual)

**Task**

b. Work with CBOs to conduct baseline and periodic PAM assessment for each cohort of beneficiaries

**Task**

c. Analyze data to create a baseline measure for each year’s cohort

**Task**

d. Use Flourish portal to assess project implementation and outreach

**Milestone #8**

Include beneficiaries in development team to promote preventive care.
### Samaritan Medical Center (PPS ID: 45)

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</table>
| **Task**
Beneficiaries are utilized as a resource in program development and awareness efforts |
| **Task**
a. Identify patient members to participate in program development and awareness efforts |
| **Task**
b. Recruit patient members to development team |
| **Task**
c. Establish meeting logistics and goals |
| **Milestone #9**
Measure PAM(R) components, including:
• Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service.
• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS’ network, assess patient using PAM(R) survey and designate a PAM(R) score.
• Individual member’s score must be averaged to calculate a baseline measure for that year’s cohort.
• The cohort must be followed for the entirety of the DSRIP program.
• On an annual basis, assess individual members’ and each cohort’s level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS’ network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP.
• The PPS will NOT be responsible for assessing the patient via PAM(R) survey.
• PPS will be responsible for providing the most current contact information to the beneficiary’s MCO for outreach purposes.
• Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis. |
| **Task**
Performance measurement reports established, including but not limited to:
- Number of patients screened, by engagement level
- Number of clinicians trained in PAM(R) survey implementation
- Number of patient: PCP bridges established
- Number of patients identified, linked by MCOs to which they... |
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<td>- Member engagement lists to DOH (for NU &amp; LU populations) on a monthly basis</td>
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<td>- Annual report assessing individual member and the overall cohort's level of engagement</td>
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<td>1. Identify and contract with Community Health Workers</td>
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<td>2. Train CHWs in connectivity to healthcare coverage, community healthcare resources and patient education</td>
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<td>3. Train CHWs to conduct PAM survey</td>
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<td>4. Ensure CHWs conduct direct hand-off to navigators and/or the appropriate level of care</td>
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<td>5. Develop ability to track co-hort</td>
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<td>6. Develop process to provide MCO most recent contact information</td>
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<td>7. Develop process to provide member engagement lists to insurance monthly and DOH quarterly</td>
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<td>1. Work with PCPs, dental health providers, behavioral health providers and MCOs to identify strategies to expand access to care for UI, NU and LU populations</td>
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<td>2. Work with PCPs, dental health providers, bheavioral health providers and MCOs to implement strategies to expand access to care for UI, NU and LU populations</td>
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<td>Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.</td>
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**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**

**Samaritan Medical Center (PPS ID:45)**

| 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 Community navigators identified and contracted. | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |        |
| Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education. | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |        |
| Task 1. Contract with CBOs for community navigator services, specific to insurance and connection to primary and community-based care |        |        |        |        |        |        |        |        |        |        |        |
| Task 2. Provide training, as needed, to community navigators to ensure seamless connectivity to preferred services (primary and preventive care) |        |        |        |        |        |        |        |        |        |        |        |
| Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service. |        |        |        |        |        |        |        |        |        |        |        |
| Task Policies and procedures for customer service complaints and appeals developed. |        |        |        |        |        |        |        |        |        |        |        |
| Task 1. Develop policies and procedures for customer service complaints and appeals |        |        |        |        |        |        |        |        |        |        |        |
| Task 2. Implement policies and procedure for customer service complaints and appeals |        |        |        |        |        |        |        |        |        |        |        |
| Task 3. Review complaints and appeals to determine process and quality improvement opportunities |        |        |        |        |        |        |        |        |        |        |        |
| Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R). |        |        |        |        |        |        |        |        |        |        |        |
| Task List of community navigators formally trained in the PAM(R). | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      | 0      |        |
| Task 1. Identify and contract with community navigators |        |        |        |        |        |        |        |        |        |        |        |
| Task 2. Train navigators in connectivity to healthcare coverage, community healthcare resources and patient education |        |        |        |        |        |        |        |        |        |        |        |
| Task 3. Train navigators to conduct PAM survey |        |        |        |        |        |        |        |        |        |        |        |
| Task 4. Ensure navigators conduct direct hand-off to the appropriate level of care |        |        |        |        |        |        |        |        |        |        |        |

NYS Confidentiality – High
## Project Requirements

<table>
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<tr>
<th>Milestone/Task Name</th>
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<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
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<tr>
<td>Ensure direct hand-offs to navigators who are prominently placed at &quot;hot spots,&quot; partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.</td>
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<td>Community navigators prominently placed (with high visibility) at appropriate locations within identified &quot;hot spot&quot; areas.</td>
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<td>Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.</td>
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<tr>
<td>Navigators educated about insurance options and healthcare resources available to populations in this project.</td>
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<td>Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.</td>
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<td>Timely access for navigator when connecting members to services.</td>
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<tr>
<td>Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.</td>
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<tr>
<td>PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.</td>
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<tr>
<td>a. Identify target patients using patient registries</td>
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</table>
Project Requirements (Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4
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Task
b. Track actively engaged patients for reporting

Prescribed Milestones Current File Uploads

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<tr>
<th>Milestone Name</th>
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Prescribed Milestones Narrative Text

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<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.</td>
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<td>Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.</td>
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<td>Identify UI, NU, and LU &quot;hot spot&quot; areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified &quot;hot spot&quot; areas.</td>
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<tr>
<td>Survey the targeted population about healthcare needs in the PPS' region.</td>
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<tr>
<td>Train providers located within &quot;hot spots&quot; on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.</td>
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<tr>
<td>Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10).</td>
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</table>
• This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall

NYS Confidentiality – High
### Prescribed Milestones Narrative Text

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<th>Milestone Name</th>
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<tbody>
<tr>
<td>focus on establishing connectivity to resources already available to the member.</td>
<td>• Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.</td>
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<tr>
<td>Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.</td>
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<td>Include beneficiaries in development team to promote preventive care.</td>
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<td>Measure PAM(R) components, including:</td>
<td>• Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or “hot spot” area for health service.</td>
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<td>• If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS’ network, assess patient using PAM(R) survey and designate a PAM(R) score.</td>
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<td>• Individual member’s score must be averaged to calculate a baseline measure for that year’s cohort.</td>
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<td>• The cohort must be followed for the entirety of the DSRIP program.</td>
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<td>• On an annual basis, assess individual members’ and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation.</td>
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<td>• If the beneficiary is deemed to be</td>
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### Prescribed Milestones Narrative Text

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| LU & NU but has a designated PCP who is not part of the PPS’ network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. | • The PPS will NOT be responsible for assessing the patient via PAM(R) survey.  
• PPS will be responsible for providing the most current contact information to the beneficiary’s MCO for outreach purposes.  
• Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis. |
| Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons. |  |
| Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education. |  |
| Develop a process for Medicaid recipients and project participants to report complaints and receive customer service. |  |
| Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R). |  |
| Ensure direct hand-offs to navigators who are prominently placed at “hot spots,” partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources. |  |
| Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations. |  |
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New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

☐ IPQR Module 2.d.i.5 - PPS Defined Milestones

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

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

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**PPS Defined Milestones Narrative Text**

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</table>
IPQR Module 2.d.i.6 - IA Monitoring

Instructions:
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: Disconnect between behavioral health, primary care and social support services (training, referrals and access to care)**
Mitigation:
a) NCI's workforce strategy will grow primary care and behavioral health capacity and back up providers so they can operate at the top of their license
b) Team-base model utilized for PCMH aligns providers
c) Utilize EHRs, the HIE and the RHIO to ensure secure, systematic record transfer
d) Increase referrals and utilization of the health home and enhance coordination with community-based organizations to help address the medical or social barriers that often time results in preventable ED visits
e) Train primary care providers to use evidence-based practices in screening (i.e. SBIRT and PHQ-9) for and treating depression, anxiety or other conditions that can be effectively managed in primary care settings

**Risk 2: Behavioral health patients have high rates of co-occurring diabetes, cardiac and respiratory diseases**
Mitigation:
a) Develop and implement standardized protocols
b) Identify the appropriate supportive services for the patient prior to discharge
c) Incorporate health literacy, cultural competency, motivational interviewing and the teach back method to activate self-care/management
d) Expand the use of tele-health remote monitoring to help patients feel connected to care

**Risk 3: Capital Costs - if capital grants are not awarded, the medical village co-location and FQHC/Primary Care clinic colocation project will be significantly impacted**
Mitigation:
a) Seek alternative funding sources other options such as Impact Model expansion vs colocation

**Risk 4: Regulatory barriers regarding co-location and patient transfers**
Mitigation:
a) Waiver requested - awaiting approval"
IPQR Module 3.a.i.2 - Project Implementation Speed

Instructions:

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

<table>
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<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
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<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<tr>
<td>Non-PCP Practitioners</td>
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<td>Clinics</td>
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<td>Community Based Organizations</td>
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<tr>
<td>All Other</td>
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<td>0</td>
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</tr>
<tr>
<td>Total Committed Providers</td>
<td>202</td>
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</tr>
<tr>
<td>Percent Committed Providers(%)</td>
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NYS Confidentiality – High
Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<tbody>
<tr>
<td></td>
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<td>DY3,Q3</td>
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<tr>
<td>Total Committed Providers</td>
<td>202</td>
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<tr>
<td>Percent Committed Providers(%)</td>
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Current File Uploads

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Narrative Text:

NYS Confidentiality – High
**IPQR Module 3.a.i.3 - Patient Engagement Speed**

**Instructions:**

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

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,000</td>
<td>2,000</td>
<td>4,000</td>
<td>8,000</td>
<td>12,000</td>
<td>3,000</td>
<td>6,000</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>16.67</td>
<td>16.67</td>
<td>33.33</td>
<td>66.67</td>
<td>100.00</td>
<td>25.00</td>
<td>50.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>9,000</td>
<td>12,000</td>
<td>3,000</td>
<td>6,000</td>
<td>9,000</td>
<td>12,000</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>75.00</td>
<td>100.00</td>
<td>25.00</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
<td>0.00</td>
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**Current File Uploads**

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**Narrative Text:**

No Records Found

NYS Confidentiality – High
IPQR Module 3.a.i.4 - Prescribed Milestones

Instructions:

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

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<thead>
<tr>
<th>Milestone/#1 (Milestone/Task Name)</th>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.</td>
<td>Model 1 Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Behavioral health services are co-located within PCMH/APC practices and are available.</td>
<td>Provider</td>
<td>Behavioral Health</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td><strong>Task</strong></td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>1. All participating practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<td></td>
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<tr>
<td><strong>Task</strong></td>
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</tr>
<tr>
<td>a. Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
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</tr>
<tr>
<td>b. Preform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
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</tr>
<tr>
<td>c. Create a project plan/timeline for each PCP</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
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</tr>
<tr>
<td>d. Implement the PCMH processes, procedures, protocols and written policies.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2017</td>
<td>09/30/2017</td>
<td>DY3 Q2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
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<td></td>
</tr>
<tr>
<td>e. Complete the NCQH Level 3 PCMH submissions</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2017</td>
<td>12/31/2017</td>
<td>DY3 Q3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
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<td></td>
</tr>
<tr>
<td>f. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong></td>
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</tr>
<tr>
<td>2. Working with the NCI 2aii project team, provide list of</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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NYS Confidentiality – High
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

<table>
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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>participating NCOA-certified and/or physicians/practitioners along with their certification documentation</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Task</strong> 3. Working with the NCI 2ai project team, provide list of practitioners and licensure performing services at PCMH and/APCM sites including behavioral health practice schedules</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Milestone #2</strong> Develop collaborative evidence-based standards of care including medication management and care engagement process.</td>
<td>Model 1</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Regularly scheduled formal meetings are held to develop collaborative care practices.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>Task</strong> Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Task</strong> 1. Collaborate with NCI Behavioral Health Committee, 2ai project team, Medical Management Committee and participating providers to develop strategies for project milestones</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Task</strong> 2. Working in collaboration with the NCI Medical Management and Care Coordination Committees, evaluate existing evidence-based standards of care including medication management and care management processes to determine NCI strategies</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Task</strong> 3. Provide meeting schedules, agendas, minutes and list of attendees</td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Task</strong> 4. Provide evidence-based practice guidelines as well as policies and procedures related to care protocols (as recommended by NCI's Care Coordination Committee), including medication management and care engagement processes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #3</strong> Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.</td>
<td>Model 1</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Policies and procedures are in place to facilitate and document completion of screenings.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID: 45)

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<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<td><strong>Project Requirements</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screenings are documented in Electronic Health Record.</td>
<td>Project</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>At least 90% of patients receive screenings at the established</td>
<td>Project</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive screenings result in &quot;warm transfer&quot; to behavioral health</td>
<td>Provider</td>
<td></td>
<td>Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
</tr>
<tr>
<td>provider as measured by documentation in Electronic Health Record.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure NCI project workforce is trained to conduct preventive care</td>
<td>Project</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>screenings such as the PHQ2 or 9 and the SBIRT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop strategy for preventive care screenings for all patients</td>
<td>Project</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>including behavioral health screenings (PHQ2 or 9 for those</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>screening positive, SBIRT)</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Provide documentation of screening policies and procedures</td>
<td>Project</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Provide screenshots or other evidence of notifications of patient</td>
<td>Project</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>identification and screening alerts to include EHR vendor</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>documentation</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide roster of identified patients receiving screenings at</td>
<td>Project</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>established project sites to include the number of screenings</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>completed</td>
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<td></td>
</tr>
<tr>
<td>Provide EHR documentation demonstrating that a &quot;warm transfer&quot;</td>
<td>Project</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>to behavioral health provider occurred if positive screening result</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Milestone #4</td>
<td>Model 1</td>
<td></td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Use EHRs or other technical platforms to track all patients</td>
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<tr>
<td>engaged in this project.</td>
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</tr>
<tr>
<td>EHR demonstrates integration of medical and behavioral health</td>
<td>Project</td>
<td></td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>record within individual patient records.</td>
<td></td>
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NYS Confidentiality – High
## Samaritan Medical Center (PPS ID:45)

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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
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<tbody>
<tr>
<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<tr>
<td><strong>Task</strong></td>
<td>In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
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<tr>
<td><strong>Task</strong></td>
<td>Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports.</td>
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<td><strong>Milestone #5</strong></td>
<td>Co-locate primary care services at behavioral health sites.</td>
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<tr>
<td><strong>Task</strong></td>
<td>PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
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<tr>
<td><strong>Task</strong></td>
<td>Primary care services are co-located within behavioral Health practices and are available.</td>
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<td><strong>Task</strong></td>
<td>Primary care services are co-located within behavioral Health practices and are available.</td>
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<tr>
<td><strong>Task</strong></td>
<td>1. All participating Primary care practices achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.</td>
<td>Provider</td>
<td>Behavioral Health</td>
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<tr>
<td><strong>Task</strong></td>
<td>1.a. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.</td>
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<td>Behavioral Health</td>
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<td><strong>Task</strong></td>
<td>1ai. Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
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<td><strong>Task</strong></td>
<td>1ai. Preform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
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<td><strong>Task</strong></td>
<td>1aiii. Create a project plan/timeline for each PCP</td>
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<td><strong>Task</strong></td>
<td>1aiiv. Implement the PCMH processes, procedures, protocols and written policies</td>
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Samaritan Medical Center (PPS ID:45)

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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<td>Task 1'av. Complete the NCQA Level 3 PCMH submissions</td>
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<td>Task 1'av. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates</td>
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<td>Task 2. Working with the NCI 2aii project team, provide list of participating NCQA-certified and/or APC-approved physicians/practitioners including certification documentation</td>
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<td>03/31/2018</td>
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<tr>
<td>Task 3. Working with NCI 2aii project team, provide list of practitioners and licensure performing services at behavioral health site including behavioral health practice schedules</td>
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<td>Task 4. Complete site and facility development at Behavioral Health site to accommodate Primary Care</td>
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<td>Task 4a. Ensure regulatory issues are identified and addressed</td>
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<td>Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.</td>
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<td>Task Regularly scheduled formal meetings are held to develop collaborative care practices.</td>
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<td>Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.</td>
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<td>03/31/2017</td>
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<td>DY2 Q4</td>
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<tr>
<td>Task Collaborate with NCI Behavioral Health Committee, 2aii project team, Medical Management Committee and participating providers to develop strategies for project milestones</td>
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<td>Task Working in collaboration with the NCI Medical Management and Care Coordination Committees, evaluate existing evidence-based standards of care including medication management and care engagement process.</td>
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<td>standards of care including medication management and care management processes to determine NCI strategies</td>
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<tr>
<td><strong>Task</strong> Provide meeting schedules, agendas, minutes and list of attendees</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td><strong>Task</strong> Provide evidence-based practice guidelines as well as policies and procedures related to care protocols (as recommended by NCI’s Care Coordination Committee), including medication management and care engagement processes</td>
<td>Project</td>
<td>In Progress</td>
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<td></td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Milestone #7</strong> Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.</td>
<td>Model 2</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.</td>
<td>Project</td>
<td>In Progress</td>
<td></td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td><strong>Task</strong> Screenings are documented in Electronic Health Record.</td>
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<td>In Progress</td>
<td></td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
<td>Project</td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Positive screenings result in &quot;warm transfer&quot; to behavioral health provider as measured by documentation in Electronic Health Record.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
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<td>DY5 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Ensure NCI project workforce is trained to conduct preventive care screenings such as the PHQ2 or 9 and the SBIRT</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td><strong>Task</strong> Develop strategy for preventive care screenings for all patients including behavioral health screenings (PHQ2 or 9 for those screening positive, SBIRT)</td>
<td>Project</td>
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<td>03/31/2017</td>
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<tr>
<td><strong>Task</strong> Provide documentation of screening policies and procedures</td>
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<td><strong>Task</strong></td>
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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name) | Project Model Name | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | --- | ---
Provide screenshots or other evidence of notifications of patient identification and screening alerts to include EHR vendor documentation |  |  |  |  |  |  |  |  
Provide roster of identified patients receiving screenings at established project sites to include the number of screenings completed | Project | In Progress | 07/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4
Task |  |  |  |  |  |  |  |  
Provide sample EHR demonstrating that "warm transfer" to behavioral health provider occurred if positive screening result | Project | In Progress | 07/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4
Task |  |  |  |  |  |  |  |  
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project. | Model 2 | Project | N/A | In Progress | 04/01/2015 | 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 | 04/01/2015 | 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 | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4
Task |  |  |  |  |  |  |  |  
In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records | Project | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4
Task |  |  |  |  |  |  |  |  
Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports. | Project | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4
Task |  |  |  |  |  |  |  |  
Milestone #9 Implement IMPACT Model at Primary Care Sites. | Model 3 | Project | N/A | In Progress | 07/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4
Task |  |  |  |  |  |  |  |  
PPS has implemented iMPACT Model at Primary Care Sites. | Provider | Primary Care Physicians | On Hold | 04/01/2015 | 03/31/2020 | 03/31/2020 | DY5 Q4
Task |  |  |  |  |  |  |  |  
In collaboration with NCI Workforce, Care Coordination and Medical Management Committees, explore and identify evidence-based IMPACT Model training programs | Project | In Progress | 07/01/2015 | 09/30/2015 | 09/30/2015 | DY1 Q2
Task |  |  |  |  |  |  |  |  
Secure IMPACT Model training program | Project | In Progress | 07/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4
Task |  |  |  |  |  |  |  |  

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<td>Identify appropriate project workforce for IMPACT model training</td>
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<td>Document commitment from project workforce for IMPACT Model training</td>
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<td>Develop and implement evidence-based strategies for the IMPACT model at identified primary care sites</td>
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<tr>
<td>Provide quarterly report narrative demonstrating successful implementation of project requirements (IMPACT Model implemented at PCP sites)</td>
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<td>Milestone #10</td>
<td>Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.</td>
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<tr>
<td>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.</td>
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<td>Policies and procedures include process for consulting with Psychiatrist.</td>
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<tr>
<td>In collaboration with NCI Workforce, Care Coordination and Medical Management Committees, ensure identified and appropriate workforce are IMPACT Model trained and able to demonstrate practical, evidence-based approaches to recognizing and treating depression in a variety of clinical settings, especially with clinically challenging cases (i.e. persistent depressions and comorbid or psychiatric conditions)</td>
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<tr>
<td>Provide documentation of evidence-based practice guidelines and protocols to include medication management and care engagement processes to facilitate collaboration between primary care physician and care manager</td>
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<tr>
<td>Provide documentation of evidence-based practice guidelines to</td>
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<td>Project</td>
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<td>include a process for consulting with Psychiatrist</td>
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<td>Task 100% of practices implementing the IMPACT model have adopted evidence-based care standards and policies and procedures for care engagement</td>
<td>Project</td>
<td>In Progress</td>
<td>Provider Type</td>
<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
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<tr>
<td>Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.</td>
<td>Model 3</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.</td>
<td>Project</td>
<td>In Progress</td>
<td>Provider Type</td>
<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP</td>
</tr>
<tr>
<td>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.</td>
<td>Project</td>
<td>In Progress</td>
<td>Provider Type</td>
<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP</td>
</tr>
<tr>
<td>Task Work with PCP practices to identify and train Depression Care Manager</td>
<td>Project</td>
<td>In Progress</td>
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<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP</td>
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<tr>
<td>Task Work with NCI IT team to ensure Depression Care Manager can be identified in the practice's EHR</td>
<td>Project</td>
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<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP</td>
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<tr>
<td>Task Provide documented evidence of IMPACT model training and implementation</td>
<td>Project</td>
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<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP</td>
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<tr>
<td>Task Provide sample EHR demonstrating relapse prevention plans, patient coaching and other IMPACT interventions</td>
<td>Project</td>
<td>In Progress</td>
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<td>Start Date</td>
<td>End Date</td>
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<tr>
<td>Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.</td>
<td>Model 3</td>
<td>Project</td>
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<td>Status</td>
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<td>End Date</td>
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<tr>
<td>Task All IMPACT participants in PPS have a designated Psychiatrist.</td>
<td>Project</td>
<td>In Progress</td>
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<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP</td>
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<tr>
<td>Task Identify consulting psychiatrists via teledmedicine who will collaborate with PCMH providers and depression care managers to provide evidence-based standards of care including medication</td>
<td>Project</td>
<td>In Progress</td>
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<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
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## Project Requirements (Milestone/Task Name)

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<tr>
<td><strong>DSRIP Implementation Plan Project</strong></td>
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<td><strong>Samaritan Medical Center (PPS ID:45)</strong></td>
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### Task

management, care engagement processes, and the integration of depression treatment into Primary Care to improve physical and social functioning

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### Task

Work in partnership with NCI IT, Medical Management and PCMH teams to ensure technological infrastructure is in place for private, secure tele-medical consults with a identified psychiatrists

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<thead>
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### Task

Provide documentation related to registration of IMPACT participants and designated Psychiatrist

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<th>Project Model Name</th>
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### Task

Provide documentation of policies and procedures related to follow up with care of patients

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<th>Project Model Name</th>
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### Task

Provide EHR documentation identifying Psychiatrist for eligible patients

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### Milestone #13

Measure outcomes as required in the IMPACT Model.

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<td>03/31/2018</td>
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### 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).

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<thead>
<tr>
<th>Project Model Name</th>
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### Task

Provide roster of screened patients

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<tr>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
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### Task

Develop protocols to ensure care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter using tools such as the PHQ2/9

<table>
<thead>
<tr>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
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### Milestone #14

Provide "stepped care" as required by the IMPACT Model.

<table>
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<tr>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
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### 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.

<table>
<thead>
<tr>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
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<th>Quarter End Date</th>
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<td>DY3 Q4</td>
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### Task

Provide documentation of evidence-based practice guidelines for stepped care including implementation plan

<table>
<thead>
<tr>
<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
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<th>End Date</th>
<th>Quarter End Date</th>
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### Task

Provide documentation of evidence-based practice guidelines for stepped care including implementation plan

<table>
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<tr>
<th>Project Model Name</th>
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<th>Provider Type</th>
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<td><strong>Project</strong></td>
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### Samaritan Medical Center (PPS ID:45)

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

<table>
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<th>Project Model Name</th>
<th>Reporting Level</th>
<th>Provider Type</th>
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<th>Start Date</th>
<th>End Date</th>
<th>Quarter</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of treatment adjusted based on clinical outcomes and according to evidence-based algorithms to include things such as medication dosages, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatment as suggested by the team psychiatrist</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2017</td>
<td>09/30/2017</td>
<td>DY3</td>
<td>Q2</td>
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<tr>
<td><strong>Task</strong> Working in collaboration with NCI clinical teams, develop targets which aim for a certain percentage (i.e. 50%) in the reduction of symptoms within a certain time period (i.e. 10-12 weeks)</td>
<td>Project</td>
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<td>DY2</td>
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<tr>
<td><strong>Milestone #15</strong> Use EHRs or other technical platforms to track all patients engaged in this project.</td>
<td>Model 3</td>
<td>Project</td>
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<tr>
<td><strong>Task</strong> EHR demonstrates integration of medical and behavioral health record within individual patient records.</td>
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<td>03/31/2017</td>
<td>DY2</td>
<td>Q4</td>
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<tr>
<td><strong>Task</strong> PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
<td>Project</td>
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<td>04/01/2015</td>
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<td>DY2</td>
<td>Q4</td>
</tr>
<tr>
<td><strong>Task</strong> In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2</td>
<td>Q4</td>
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<tr>
<td><strong>Task</strong> Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports.</td>
<td>Project</td>
<td>In Progress</td>
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#### Project Requirements (Milestone/Task Name)

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<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
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<tbody>
<tr>
<td>Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.</td>
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<tr>
<td><strong>Task</strong> All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.</td>
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<td>Behavioral health services are co-located within PCMH/APC</td>
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NYS Confidentiality – High
## Project Requirements

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<tr>
<td>All participating practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.</td>
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<td>Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
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<tr>
<td>Perform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
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<td>Create a project plan/timeline for each PCP</td>
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<tr>
<td>Implement the PCMH processes, procedures, protocols and written policies.</td>
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<td>Complete the NCQA Level 3 PCMH submissions</td>
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<tr>
<td>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates.</td>
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<td>Working with the NCI 2aii project team, provide list of participating NCQA-certified and/or physicians/practitioners along with their certification documentation.</td>
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<td>Working with the NCI 2aii project team, provide list of practitioners and licensure performing services at PCMH and/APCM sites including behavioral health practice schedules.</td>
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<td>Develop collaborative evidence-based standards of care including medication management and care engagement process.</td>
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<td>Regularly scheduled formal meetings are held to develop collaborative care practices.</td>
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<td>Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.</td>
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<td>Collaborate with NCI Behavioral Health Committee, 2aii project team, Medical Management Committee and participating providers to develop strategies for project.</td>
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### Project Requirements (Milestone/Task Name)

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<tr>
<td>Task 2. Working in collaboration with the NCI Medical Management and Care Coordination Committees, evaluate existing evidence-based standards of care including medication management and care management processes to determine NCI strategies.</td>
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<td>Task 4. Provide evidence-based practice guidelines as well as policies and procedures related to care protocols (as recommended by NCI's Care Coordination Committee), including medication management and care engagement processes.</td>
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#### 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.
- **Task** Ensure NCI project workforce is trained to conduct preventive care screenings such as the PHQ2 or 9 and the SBIRT.
- **Task** Develop strategy for preventive care screenings for all patients including behavioral health screenings (PHQ2 or 9 for those screening positive, SBIRT).
- **Task** Provide documentation of screening policies and procedures.

NYS Confidentiality – High
## 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** Provide screenshots or other evidence of notifications of patient identification and screening alerts to include EHR vendor documentation  
**Task** Provide roster of identified patients receiving screenings at established project sites to include the number of screenings completed  
**Task** Provide EHR documentation demonstrating that a "warm transfer" to behavioral health provider occurred if positive screening result

### 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** In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records.

**Task** Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports.

### 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 0 0 0 0 0

**Task** Primary care services are co-located within behavioral Health practices and are available. 0 0 0 0 0 0 0 0 0 0

**Task** Primary care services are co-located within behavioral Health practices and are available. 0 0 0 0 0 0 0 0 0 0

**Task** 1. All participating Primary care practices achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.
# Samaritan Medical Center (PPS ID: 45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<td>Task 1.a. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.</td>
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<td>Task 1ai. Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
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<td>Task 1aii. Perform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
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<td>Task 1aiii. Create a project plan/timeline for each PCP</td>
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<td>Task 1aiv. Implement the PCMH processes, procedures, protocols and written policies</td>
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<td>Task 1av. Complete the NCQA Level 3 PCMH submissions</td>
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<td>Task 1avi. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates</td>
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<td>Task 2. Working with NCI 2aii project team, provide list of participating NCQA-certified and/or APC-approved physicians/practitioners including certification documentation</td>
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<td>Task 3. Working with NCI 2aii project team, provide list of practitioners and licensure performing services at behavioral health site including behavioral health practice schedules</td>
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<td>Task 4. Complete site and facility development at Behavioral Health site to accommodate Primary Care</td>
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<td>Task 4a. Ensure regulatory issues are identified and addressed</td>
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<td>Task 4b. Ensure physical plant issues identified and addressed</td>
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**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.

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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<td>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.</td>
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<td>Collaborate with NCI Behavioral Health Committee, 2aii project team, Medical Management Committee and participating providers to develop strategies for project milestones</td>
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<td>Working in collaboration with the NCI Medical Management and Care Coordination Committees, evaluate existing evidence-based standards of care including medication management and care management processes to determine NCI strategies</td>
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<td>Provide evidence-based practice guidelines as well as policies and procedures related to care protocols (as recommended by NCI's Care Coordination Committee), including medication management and care engagement processes</td>
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<td>Conduction of preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.</td>
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<td>Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.</td>
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<td>Screenings are documented in Electronic Health Record.</td>
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<td>At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
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<td>Positive screenings result in &quot;warm transfer&quot; to behavioral health provider as measured by documentation in Electronic Health Record.</td>
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<td>Ensure NCI project workforce is trained to conduct preventive care screenings such as the PHQ2 or 9 and the SBIRT</td>
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<td>Develop strategy for preventive care screenings for all patients</td>
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<tr>
<td>including behavioral health screenings (PHQ2 or 9 for those screening positive, SBIRT)</td>
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<td>Task</td>
<td>Provide documentation of screening policies and procedures</td>
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<td>Provide screenshots or other evidence of notifications of patient identification and screening alerts to include EHR vendor documentation</td>
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<td>Task</td>
<td>Provide roster of identified patients receiving screenings at established project sites to include the number of screenings completed</td>
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<td>Task</td>
<td>Provide sample EHR demonstrating that &quot;warm transfer&quot; to behavioral health provider occurred if positive screening result</td>
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<td>Milestone #8</td>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<td>Task</td>
<td>EHR demonstrates integration of medical and behavioral health record within individual patient records.</td>
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<td>Task</td>
<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td>Task</td>
<td>In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records</td>
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<td>Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports.</td>
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<td>Milestone #9</td>
<td>Implement IMPACT Model at Primary Care Sites.</td>
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<td>Task</td>
<td>In collaboration with NCI Workforce, Care Coordination and Medical Management Committees, explore and identify evidence-based IMPACT Model training programs</td>
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<td>Secure IMPACT Model training program</td>
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NYS Confidentiality – High
## New York State Department Of Health
### Delivery System Reform Incentive Payment Project
### DSRIP Implementation Plan Project

#### Samaritan Medical Center (PPS ID: 45)

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<td>Task Develop and implement evidence-based strategies for the IMPACT model at identified primary care sites</td>
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<td>Task Provide quarterly report narrative demonstrating successful implementation of project requirements (IMPACT Model implemented at PCP sites)</td>
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<td>Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.</td>
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<td>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.</td>
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<td>Task Policies and procedures include process for consulting with Psychiatrist.</td>
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<td>Task In collaboration with NCI Workforce, Care Coordination and Medical Management Committees, ensure identified and appropriate workforce are IMPACT Model trained and able to demonstrate practical, evidence-based approaches to recognizing and treating depression in a variety of clinical settings, especially with clinically challenging cases (i.e., persistent depressions and comorbid or psychiatric conditions)</td>
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<td>Task Provide documentation of evidence-based practice guidelines and protocols to include medication management and care engagement processes to facilitate collaboration between primary care physician and care manager</td>
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<td>Task Provide documentation of evidence-based practice guidelines to include a process for consulting with Psychiatrist</td>
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<td>Task 100% of practices implementing the IMPACT model have adopted evidence-based care standards and policies and</td>
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<th>Project Requirements (Milestone/Task Name)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
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<tr>
<td>procedures for care engagement</td>
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<td>Milestone #11</td>
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<td>Employ a trained Depression Care Manager meeting requirements of the IMPACT model.</td>
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<td>PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.</td>
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<td>Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.</td>
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<td>Work with PCP practices to identify and train Depression Care Manager</td>
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<td>Work with NCI IT team to ensure Depression Care Manager can be identified in the practice’s EHR</td>
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<td>Provide documented evidence of IMPACT model training and implementation</td>
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<td>Provide sample EHR demonstrating relapse prevention plans, patient coaching and other IMPACT interventions</td>
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<td>Designate a Psychiatrist meeting requirements of the IMPACT Model.</td>
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<td>All IMPACT participants in PPS have a designated Psychiatrist.</td>
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<tr>
<td>Identify consulting psychiatrists via telemedicine who will collaborate with PCMH providers and depression care managers to provide evidence-based standards of care including medication management, care engagement processes, and the integration of depression treatment into Primary Care to improve physical and social functioning</td>
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<td>Work in partnership with NCI IT, Medical Management and PCMH teams to ensure technological infrastructure is in place for private, secure tele-medical consults with a identified psychiatrists</td>
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**New York State Department Of Health**  
**Delivery System Reform Incentive Payment Project**  
**DSRIP Implementation Plan Project**  

**Samaritan Medical Center (PPS ID:45)**

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<tr>
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<th>DY2,Q4</th>
<th>DY3,Q1</th>
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</thead>
<tbody>
<tr>
<td><strong>Task</strong> Provide documentation related to registration of IMPACT participants and designated Psychiatrist</td>
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<tr>
<td><strong>Task</strong> Provide documentation of policies and procedures related to follow up with care of patients</td>
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<tr>
<td><strong>Task</strong> Provide EHR documentation identifying Psychiatrist for eligible patients</td>
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<td><strong>Milestone #13</strong> Measure outcomes as required in the IMPACT Model.</td>
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<td><strong>Task</strong> At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
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<td><strong>Task</strong> Provide roster of screened patients</td>
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<td><strong>Task</strong> Develop protocols to ensure care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter using tools such as the PHQ2/9</td>
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<td><strong>Milestone #14</strong> Provide &quot;stepped care&quot; as required by the IMPACT Model.</td>
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<tr>
<td><strong>Task</strong> In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.</td>
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<td><strong>Task</strong> Provide documentation of evidence-based practice guidelines for stepped care including implementation plan</td>
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<td><strong>Task</strong> Documentation of treatment adjusted based on clinical outcomes and according to evidence-based algorithms to include things such as medication dosages, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatment as suggested by the team psychiatrist</td>
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<td><strong>Task</strong> Working in collaboration with NCI clinical teams, develop targets which aim for a certain percentage (i.e. 50%) in the reduction of symptoms within a certain time period (i.e. 10-12 weeks)</td>
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<td><strong>Milestone #15</strong> Use EHRs or other technical platforms to track all patients</td>
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NYS Confidentiality – High
# Samaritan Medical Center (PPS ID:45)

## Project Requirements

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<tr>
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<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tr>
<td>engaged in this project.</td>
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<td>Task EHR demonstrates integration of medical and behavioral health record within individual patient records.</td>
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<td>Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td>Task In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records.</td>
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<td>Task Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports.</td>
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## 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.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
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<th>DY4,Q3</th>
<th>DY4,Q4</th>
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<th>DY5,Q2</th>
<th>DY5,Q3</th>
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<tr>
<td>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.</td>
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<td>Behavioral health services are co-located within PCMH/APC practices and are available.</td>
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<td>1. All participating practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.</td>
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<td>a. Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
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<td>b. Perform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
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<td>c. Create a project plan/timeline for each PCP.</td>
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<td>d. Implement the PCMH processes, procedures, protocols and written policies.</td>
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**Project Requirements**  
(Milestone/Task Name) | DY3,Q3 | DY3,Q4 | DY4,Q1 | DY4,Q2 | DY4,Q3 | DY4,Q4 | DY5,Q1 | DY5,Q2 | DY5,Q3 | DY5,Q4
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
Task e. Complete the NCQA Level 3 PCMH submissions |  |  |  |  |  |  |  |  |  |  
Task f. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates |  |  |  |  |  |  |  |  |  |  
Task 2. Working with the NCI 2aii project team, provide list of participating NCQA-certified and/or physicians/practitioners along with their certification documentation |  |  |  |  |  |  |  |  |  |  
Task 3. Working with the NCI 2aii project team, provide list of practitioners and licensure performing services at PCMH and/APCM sites including behavioral health practice schedules |  |  |  |  |  |  |  |  |  |  
**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 1. Collaborate with NCI Behavioral Health Committee, 2aii project team, Medical Management Committee and participating providers to develop strategies for project milestones |  |  |  |  |  |  |  |  |  |  
Task 2. Working in collaboration with the NCI Medical Management and Care Coordination Committees, evaluate existing evidence-based standards of care including medication management and care management processes to determine NCI strategies |  |  |  |  |  |  |  |  |  |  
Task 3. Provide meeting schedules, agendas, minutes and list of attendees |  |  |  |  |  |  |  |  |  |  
Task 4. Provide evidence-based practice guidelines as well as policies and procedures related to care protocols (as recommended by NCI's Care Coordination Committee), including medication management and care engagement processes |  |  |  |  |  |  |  |  |  |  

NYS Confidentiality – High
### Samaritan Medical Center (PPS ID:45)

#### Project Requirements

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<td>Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.</td>
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<td>Task</td>
<td>Policies and procedures are in place to facilitate and document completion of screenings.</td>
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<td>Task</td>
<td>Screenings are documented in Electronic Health Record.</td>
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<td>Task</td>
<td>At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
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<td>Task</td>
<td>Positive screenings result in &quot;warm transfer&quot; to behavioral health provider as measured by documentation in Electronic Health Record.</td>
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<td>Task</td>
<td>Ensure NCI project workforce is trained to conduct preventive care screenings such as the PHQ2 or 9 and the SBIRT.</td>
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<td>Task</td>
<td>Develop strategy for preventive care screenings for all patients including behavioral health screenings (PHQ2 or 9 for those screening positive, SBIRT)</td>
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<td>Task</td>
<td>Provide documentation of screening policies and procedures</td>
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<td>Task</td>
<td>Provide screenshots or other evidence of notifications of patient identification and screening alerts to include EHR vendor documentation</td>
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<td>Task</td>
<td>Provide roster of identified patients receiving screenings at established project sites to include the number of screenings completed</td>
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<td>Task</td>
<td>Provide EHR documentation demonstrating that a &quot;warm transfer&quot; to behavioral health provider occurred if positive screening result</td>
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<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<td>Task</td>
<td>EHR demonstrates integration of medical and behavioral health</td>
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<td>record within individual patient records.</td>
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<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td>In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records.</td>
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<td>Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports.</td>
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<td>Co-locate primary care services at behavioral health sites.</td>
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<td>PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.</td>
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<td>Primary care services are co-located within behavioral Health practices and are available.</td>
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<td>1. All participating Primary care practices achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.</td>
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<td>1.a. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.</td>
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<td>1ai. Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
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<td>1aii. Perform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
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<td>1aiii. Create a project plan/timeline for each PCP</td>
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<td>1aiiv. Implement the PCMH processes, procedures, protocols and written policies</td>
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<td>1av. Complete the NCQA Level 3 PCMH submissions</td>
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NYS Confidentiality – High
# Samaritan Medical Center (PPS ID: 45)

## Project Requirements

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<td>1avi. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates</td>
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<td>2. Working with the NCI 2aii project team, provide list of participating NCQA-certified and/or APC-approved physicians/practitioners including certification documentation</td>
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<td>3. Working with NCI 2aii project team, provide list of practitioners and licensure performing services at behavioral health site including behavioral health practice schedules</td>
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<td>4. Complete site and facility development at Behavioral Health site to accommodate Primary Care</td>
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<td>4a. Ensure regulatory issues are identified and addressed</td>
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<td>4b. Ensure physical plant issues identified and addressed</td>
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<td>Develop collaborative evidence-based standards of care including medication management and care engagement process.</td>
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<td>Regularly scheduled formal meetings are held to develop collaborative care practices.</td>
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<td>Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.</td>
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<td>Collaborate with NCI Behavioral Health Committee, 2aii project team, Medical Management Committee and participating providers to develop strategies for project milestones</td>
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<td>Working in collaboration with the NCI Medical Management and Care Coordination Committees, evaluate existing evidence-based standards of care including medication management and care management processes to determine NCI strategies</td>
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<td>Provide meeting schedules, agendas, minutes and list of attendees</td>
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<td>Provide evidence-based practice guidelines as well as policies and procedures related to care protocols (as recommended by NCI's Care Coordination Committee), including medication management and care engagement processes</td>
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<td>Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.</td>
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<td>Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.</td>
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<td>Screenings are documented in Electronic Health Record.</td>
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<td>At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).</td>
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<td>Positive screenings result in “warm transfer” to behavioral health provider as measured by documentation in Electronic Health Record.</td>
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<td>Ensure NCI project workforce is trained to conduct preventive care screenings such as the PHQ2 or 9 and the SBIRT</td>
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<td>Develop strategy for preventive care screenings for all patients including behavioral health screenings (PHQ2 or 9 for those screening positive, SBIRT)</td>
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<td>Provide documentation of screening policies and procedures</td>
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<td>Provide screenshots or other evidence of notifications of patient identification and screening alerts to include EHR vendor documentation</td>
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<td>Provide roster of identified patients receiving screenings at established project sites to include the number of screenings completed</td>
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<td>Provide sample EHR demonstrating that “warm transfer” to behavioral health provider occurred if positive screening result</td>
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### Project Requirements (Milestone/Task Name)

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<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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<tr>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<td>Task EHR demonstrates integration of medical and behavioral health record within individual patient records.</td>
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<td>Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<tr>
<td>Task In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records.</td>
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<td>Task Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports.</td>
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### Milestone #9

**Implement IMPACT Model at Primary Care Sites.**

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<td>PPS has implemented IMPACT Model at Primary Care Sites.</td>
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<td>Task In collaboration with NCI Workforce, Care Coordination and Medical Management Committees, explore and identify evidence-based IMPACT Model training programs</td>
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<td>Task Secure IMPACT Model training program</td>
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<td>Task Identify appropriate project workforce for IMPACT model training</td>
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<td>Task Document commitment from project workforce for IMPACT Model training</td>
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<td>Task Develop and implement evidence-based strategies for the IMPACT model at identified primary care sites</td>
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<td>Task Provide quarterly report narrative demonstrating successful implementation of project requirements (IMPACT Model implemented at PCP sites)</td>
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### Milestone #10

**Utilize IMPACT Model collaborative care standards, including**

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### Samaritan Medical Center (PPS ID: 45)

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<tbody>
<tr>
<td>Developing coordinated evidence-based care standards and policies and procedures for care engagement.</td>
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<td>Developing coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.</td>
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<td>Policies and procedures include process for consulting with Psychiatrist.</td>
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<tr>
<td>In collaboration with NCI Workforce, Care Coordination and Medical Management Committees, ensure identified and appropriate workforce are IMPACT Model trained and able to demonstrate practical, evidence-based approaches to recognizing and treating depression in a variety of clinical settings, especially with clinically challenging cases (i.e. persistent depressions and comorbid or psychiatric conditions)</td>
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<td>Provide documentation of evidence-based practice guidelines and protocols to include medication management and care engagement processes to facilitate collaboration between primary care physician and care manager</td>
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<td>Provide documentation of evidence-based practice guidelines to include a process for consulting with Psychiatrist</td>
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<td>100% of practices implementing the IMPACT model have adopted evidence-based care standards and policies and procedures for care engagement</td>
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<td>Employ a trained Depression Care Manager meeting requirements of the IMPACT model.</td>
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<td>PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.</td>
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<td>Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.</td>
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## Project Requirements

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<td>Work with PCP practices to identify and train Depression Care Manager</td>
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<td>Work with NCI IT team to ensure Depression Care Manager can be identified in the practice's EHR</td>
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<td>Provide documented evidence of IMPACT model training and implementation</td>
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<td>Provide sample EHR demonstrating relapse prevention plans, patient coaching and other IMPACT interventions</td>
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<td>Designate a Psychiatrist meeting requirements of the IMPACT Model</td>
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<td>All IMPACT participants in PPS have a designated Psychiatrist</td>
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<td>Identify consulting psychiatrists via telemedicine who will collaborate with PCMH providers and depression care managers to provide evidence-based standards of care including medication management, care engagement processes, and the integration of depression treatment into Primary Care to improve physical and social functioning</td>
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<td>Work in partnership with NCI IT, Medical Management and PCMH teams to ensure technological infrastructure is in place for private, secure tele-medical consults with a identified psychiatrists</td>
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<td>Provide documentation related to registration of IMPACT participants and designated Psychiatrist</td>
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<td>Provide documentation of policies and procedures related to follow up with care of patients</td>
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<td>Provide EHR documentation identifying Psychiatrist for eligible patients</td>
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<td>Measure outcomes as required in the IMPACT Model</td>
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<tr>
<td>At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screenings</td>
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NYS Confidentiality – High
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>positive, SBIRT.</td>
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<tr>
<td>Provide roster of screened patients</td>
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<tr>
<td>Develop protocols to ensure care managers measure depressive symptoms at the start of a patient’s treatment and regularly thereafter using tools such as the PHQ2/9</td>
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<tr>
<td><strong>Milestone #14</strong></td>
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<tr>
<td>Provide &quot;stepped care&quot; as required by the IMPACT Model.</td>
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<tr>
<td>In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.</td>
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<tr>
<td>Provide documentation of evidence-based practice guidelines for stepped care including implementation plan</td>
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<tr>
<td>Documentation of treatment adjusted based on clinical outcomes and according to evidence-based algorithms to include things such as medication dosages, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatment as suggested by the team psychiatrist</td>
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<tr>
<td>Working in collaboration with NCI clinical teams, develop targets which aim for a certain percentage (i.e. 50%) in the reduction of symptoms within a certain time period (i.e. 10-12 weeks)</td>
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<tr>
<td><strong>Milestone #15</strong></td>
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<tr>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<tr>
<td>EHR demonstrates integration of medical and behavioral health record within individual patient records.</td>
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<tr>
<td>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<tr>
<td>In collaboration with NCI’s IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records</td>
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<tr>
<td>Working in collaboration with NCI’s IT, data and clinical team.</td>
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</table>

NYS Confidentiality – High
gather data and track target patients by using EHR reports.

Prescribed Milestones 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.

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

**Instructions:**

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

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
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### PPS Defined Milestones Current File Uploads

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

### PPS Defined Milestones Narrative Text

<table>
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<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Records Found</td>
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</table>

NYS Confidentiality – High
<table>
<thead>
<tr>
<th>IPQR Module 3.a.i.6 - IA Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Instructions:</strong></td>
</tr>
</tbody>
</table>

Model 1, Milestone 1: The IA recommends updating the timeline for required tasks with reasonable start and end dates and expanding project tasks to adequately document the process for achieving the Milestone, including: bringing primary care practices in compliance with 2014 standards, monitoring of progress, integrating behavioral health services into the practices.

Model 2, Milestone 5: The IA recommends building out tasks related to the process of practice integration, including addressing regulatory issues, site development, and addressing certification by NCQA of developed sites.

Model 3, Milestone 10: Add task that addresses monitoring process.
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.

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Mitigation Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk: Changing the behavior of Medicaid patients.</td>
<td>a.) Establishing a schedule for community outreach and creating awareness on services and supports available. b.) Providing health literacy and competency training for members providing care. c.) Coordinating with PHIP activities to ensure the people residing in high-risk hotspots are engaged at the neighborhood and community level.</td>
</tr>
<tr>
<td>Risk: Adding clinical decision support into EMR systems</td>
<td>a.) A plan has been established to not turn on all CDS, just those that impact the evidence-based guidelines chosen. b.) HIT implementation specialist will work with office to assist in the proper use of CDS</td>
</tr>
<tr>
<td>Risk: Adoption of PCMH 2014 standards</td>
<td>a.) PCMH certified content experts will be deployed to assist offices in obtaining PCMH level 3 2014 certification.</td>
</tr>
<tr>
<td>Risk: Access to Blood Pressure screenings and variation in screening techniques</td>
<td></td>
</tr>
<tr>
<td>Risk: Existing provider gaps and access to care issues</td>
<td>a.) The workforce committee has established a plan for recruitment and retention of new provider’s b.) Enhancements to GME program c.) Care coordination to assist the chronically ill with access to care.</td>
</tr>
</tbody>
</table>
IPQR Module 3.b.i.2 - Project Implementation Speed

Instructions:

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>47</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>91</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinics</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>28</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Committed Providers</strong></td>
<td><strong>185</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Percent Committed Providers(%)</strong></td>
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<td>0.00</td>
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NYS Confidentiality – High
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<tbody>
<tr>
<td></td>
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<td>DY3,Q3</td>
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<tr>
<td>Substance Abuse</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>185</td>
<td>0</td>
</tr>
<tr>
<td>Percent Committed Providers(%)</td>
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**Current File Uploads**

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**Narrative Text:**

No Records Found

NYS Confidentiality – High
**IPQR Module 3.b.i.3 - Patient Engagement Speed**

**Instructions:**

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

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

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>382</td>
<td>573</td>
<td>1,146</td>
<td>2,484</td>
<td>3,822</td>
<td>2,293</td>
<td>4,587</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>5.00</td>
<td>7.50</td>
<td>14.99</td>
<td>32.49</td>
<td>49.99</td>
<td>29.99</td>
<td>60.00</td>
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<table>
<thead>
<tr>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>6,116</td>
<td>7,645</td>
<td>1,911</td>
<td>3,823</td>
<td>5,734</td>
<td>7,645</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent of Expected Patient Engagement(%)</td>
<td>80.00</td>
<td>100.00</td>
<td>25.00</td>
<td>50.01</td>
<td>75.00</td>
<td>100.00</td>
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**Narrative Text:**

No Records Found
### Recipients

#### Samaritan Medical Center (PPS ID:45)

**IPQR Module 3.b.i.4 - Prescribed Milestones**

Instructions:

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

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Task</td>
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</tr>
<tr>
<td>PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>Task</td>
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</tr>
<tr>
<td>1. Assess and Stratify population into risk categories.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td>Task</td>
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</tr>
<tr>
<td>2. Assess and Stratify population lifestyle approaches to prevent CVD.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
<td></td>
</tr>
<tr>
<td>Task</td>
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</tr>
<tr>
<td>3. Determine other CVD risk-reducing interventions and categorize by priority based on class recommendation.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
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<tr>
<td>4. Develop a program to improve CVD that utilizes evidence-based strategies and stratified data in the ambulatory setting.</td>
<td>Project</td>
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<tr>
<td>5. Develop a program to improve CVD that utilizes evidence-based strategies and stratified data in community care setting.</td>
<td>Project</td>
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<tr>
<td>6. Conducting CVD training and awareness for population, ambulatory and community based organizations</td>
<td>Project</td>
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<td>06/30/2017</td>
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<tr>
<td>7. Implement program to improve CVD management using evidence-based strategies in the ambulatory and community based setting.</td>
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<tr>
<td>8. Monitor and control CVD program management in the ambulatory and community based settings.</td>
<td>Project</td>
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<td>03/31/2018</td>
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<tr>
<td>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</td>
<td>Project</td>
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**NYS Confidentiality – High**
### Project Requirements (Milestone/Task Name)

<table>
<thead>
<tr>
<th>Health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
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<tr>
<td>Status</td>
</tr>
<tr>
<td>Start Date</td>
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<td>End Date</td>
</tr>
<tr>
<td>Quarter End Date</td>
</tr>
<tr>
<td>DSRIP Reporting Year and Quarter</td>
</tr>
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</table>

| Task | EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. |
| Provider | Safety Net Non-PCP Practitioners |
| Status | On Hold |
| Start Date | 04/01/2015 |
| End Date | 03/31/2020 |
| Quarter End Date | 03/31/2020 |
| DSRIP Reporting Year and Quarter | DY5 Q4 |

| Task | EHR meets connectivity to RHIO's HIE and SHIN-NY requirements. |
| Provider | Safety Net Behavioral Health |
| Status | On Hold |
| Start Date | 04/01/2015 |
| End Date | 03/31/2020 |
| Quarter End Date | 03/31/2020 |
| DSRIP Reporting Year and Quarter | DY5 Q4 |

| Task | PPS uses alerts and secure messaging functionality. |
| Provider Type | In Progress |
| Start Date | 04/01/2015 |
| End Date | 03/31/2018 |
| Quarter End Date | 03/31/2018 |
| DSRIP Reporting Year and Quarter | DY3 Q4 |

| Task | 1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS. |
| Provider Type | In Progress |
| Start Date | 04/01/2015 |
| End Date | 03/31/2016 |
| Quarter End Date | 03/31/2016 |
| DSRIP Reporting Year and Quarter | DY1 Q4 |

| Task | 2. Perform a gap analysis and a plan with budget to address the identified needs |
| Provider Type | In Progress |
| Start Date | 04/01/2015 |
| End Date | 03/31/2016 |
| Quarter End Date | 03/31/2016 |
| DSRIP Reporting Year and Quarter | DY1 Q4 |

| Task | 3. Begin implementations with prioritization based on attributed Medicaid population and provider engagement. |
| Provider Type | In Progress |
| Start Date | 04/01/2015 |
| End Date | 03/31/2016 |
| Quarter End Date | 03/31/2016 |
| DSRIP Reporting Year and Quarter | DY1 Q4 |

| Task | 4. During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, & issues are communicated and a plan is in place to address them. |
| Provider Type | In Progress |
| Start Date | 04/01/2015 |
| End Date | 06/30/2016 |
| Quarter End Date | 06/30/2016 |
| DSRIP Reporting Year and Quarter | DY2 Q1 |

| Task | 5. Perform a post-go-live gap analysis and a plan with budget to address the identified needs |
| Provider Type | In Progress |
| Start Date | 04/01/2015 |
| End Date | 03/31/2017 |
| Quarter End Date | 03/31/2017 |
| DSRIP Reporting Year and Quarter | DY2 Q4 |

| Task | 6. Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care. |
| Provider Type | In Progress |
| Start Date | 04/01/2015 |
| End Date | 03/31/2018 |
| Quarter End Date | 03/31/2018 |
| DSRIP Reporting Year and Quarter | DY3 Q4 |

| Milestone #3 | Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3. |
| Provider Type | N/A |
| Start Date | 04/01/2015 |
| End Date | 03/31/2018 |
| Quarter End Date | 03/31/2018 |
| DSRIP Reporting Year and Quarter | DY3 Q4 |

<p>| Task | EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment) |
| Provider Type | In Progress |
| Start Date | 04/01/2015 |
| End Date | 03/31/2018 |
| Quarter End Date | 03/31/2018 |
| DSRIP Reporting Year and Quarter | DY3 Q4 |</p>
<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>Provider Type</th>
<th>Status</th>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
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<tbody>
<tr>
<td>Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
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<td>03/31/2020</td>
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<tr>
<td>Task 1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.</td>
<td>Project</td>
<td>In Progress</td>
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<td>03/31/2016</td>
<td>03/31/2016</td>
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<tr>
<td>Task 2. Perform a gap analysis and a plan with budget to address the identified needs</td>
<td>Project</td>
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<td>03/31/2016</td>
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</tr>
<tr>
<td>Task 3. Perform a pre-MU and PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to attest for MU and apply for NCQA PCMH by DSRIP DY3.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
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<tr>
<td>Task 4. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
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</tr>
<tr>
<td>Task 5. During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, &amp; issues are communicated and a plan is in place to address them.</td>
<td>Project</td>
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<td>06/30/2016</td>
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<tr>
<td>Task 6. Perform a post-go-live gap analysis and a plan with budget to address the identified needs</td>
<td>Project</td>
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<td>03/31/2018</td>
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<tr>
<td>Task 7. Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</td>
<td>Project</td>
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<td>03/31/2018</td>
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<tr>
<td>Milestone #4</td>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<tr>
<td>Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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NYS Confidentiality – High
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<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<td>Task 1. Identify targeted patient population through data collection</td>
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<td>Task 2. Track / Monitor actively engaged patients utilizing designated tracking systems</td>
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<td>Task 3. Report actively engaged patients against milestone completion</td>
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<td>Task 4. Routinely Measure outcomes through quality assessment</td>
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<tr>
<td>Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).</td>
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<tr>
<td>Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.</td>
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<td>Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.</td>
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<td>Task 1. Assess EMR systems limitations and capabilities for incorporation of 5A's</td>
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<td>Task 2. Promote direct conversation of 5A's between patient /clinician</td>
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<td>06/30/2016</td>
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<td>Task 3. Identify and Stratify population into tobacco use and non-tobacco categories.</td>
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<td>Task 4. Formulate data collection to create patient tobacco use listings</td>
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<td>Task 5. Train staff to incorporate EHR to prompt the use of 5A's of tobacco control</td>
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<td>Task 6. Implement an automated or work driver scheduling system to facilitate tobacco control protocols.</td>
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<tr>
<td>Task 7. Practioners and Clinics document in EHR system patient tobacco use status</td>
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<td>Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.</td>
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<tr>
<td>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).</td>
<td>Project</td>
<td>In Progress</td>
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<td>Provider Type</td>
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<td>Start Date</td>
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<tr>
<td>Task</td>
<td>1. Practices will provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
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<td>Task</td>
<td>2. Make hypertension control a priority in practices and health systems and identify the protocols in achieving control of blood pressure for hypertensive patients</td>
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<td>Task</td>
<td>3. Identify patients who have repeated elevated blood pressure readings in their medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.</td>
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<td>Task</td>
<td>4. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<td>Task</td>
<td>5. Provide training to ensure attainment of correct blood pressure measurements</td>
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<td>Task</td>
<td>6. Conduct pre-visit planning to ensure blood pressure is a focus of patient visits</td>
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<td>12/31/2016</td>
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<tr>
<td>Task</td>
<td>7. Incorporate coaching and self-management into patient educations and follow-up visits</td>
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<td>12/31/2016</td>
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<tr>
<td>Task</td>
<td>8. Practices will adopt treatment protocols that align with national guidelines: US Preventive Task Force (USPSTF) or National Cholesterol Education Program (NCEP)</td>
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<tr>
<td>Milestone #7</td>
<td>Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.</td>
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<tr>
<td>Task</td>
<td>Clinically Interoperable System is in place for all participating providers.</td>
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<td>03/31/2017</td>
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<tr>
<td>Task</td>
<td>Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
<td>Project</td>
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<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
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NYS Confidentiality – High
New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>Care coordination processes are in place.</td>
<td></td>
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<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
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<tr>
<td><strong>Task</strong> 1. Form care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers.</td>
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<tr>
<td><strong>Task</strong> 2. Implement care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
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<td>In Progress</td>
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<td><strong>Task</strong> 3. Validate Care coordination processes are in place.</td>
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<tr>
<td><strong>Task</strong> 4. All participating providers will have a Clinically Interoperable System in place.</td>
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<td><strong>Milestone #8</strong> Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
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<tr>
<td><strong>Task</strong> All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.</td>
<td>Provider Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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</tr>
<tr>
<td><strong>Task</strong> 1. Provide patient training to ensure attainment of correct blood pressure measurements</td>
<td>Provider Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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</tr>
<tr>
<td><strong>Task</strong> 2. Practices will provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
<td>Provider Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 3. Incorporate coaching and self-management into patient educations and follow-up visits</td>
<td>Provider Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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</tr>
<tr>
<td><strong>Milestone #9</strong> Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.</td>
<td>Provider Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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</tr>
<tr>
<td><strong>Task</strong> PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.</td>
<td>Provider Primary Care Physicians</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td><strong>Task</strong> 1. Conduct training to ensure attainment of correct blood pressure measurements</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td><strong>Task</strong> 2. Document blood pressure readings in EMR system</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
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<tr>
<td><strong>Task</strong> 3. Conduct annual assessment and attestation of health care staffs</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
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<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>Understanding of correct blood pressure measurement techniques and equipment.</td>
<td>Milestone #10</td>
<td>Project</td>
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<td>07/01/2015</td>
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<tr>
<td>Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td>PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.</td>
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<td>Project</td>
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<td>In Progress</td>
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<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td>PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td>PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
</tr>
<tr>
<td>1. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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<tr>
<td>2. Make hypertension control a priority in practices and health systems and identify the protocol's in achieving control of blood pressure for hypertensive patients.</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>3. Conduct pre-visit planning to ensure blood pressure is a focus of patient visits</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
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<tr>
<td>Prescribe once-daily regimens or fixed-dose combination pills when appropriate.</td>
<td>Milestone #11</td>
<td>Project</td>
<td>N/A</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>1. Encourage patients to use medication reminders.</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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<tr>
<td>2. Ensure patients understand their risks if they do not take medications as directed.</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
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<tr>
<td>3. Confirm medication benefits with patients.</td>
<td>Task</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
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</table>
### Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
Task 4. Educate patients on the use of medication reminders. | Project | In Progress | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2 |
Task 5. Implement protocols for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors. | Project | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
Task 6. Provide once daily regimens or fixed-dosed combination pills when appropriate. | Project | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |
Task 7. Conduct frequent / routine follow-ups with patients | Project | In Progress | 04/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4 |

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

| Task | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
Task | N/A | In Progress | 07/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |

**Milestone #13**
Follow up with referrals to community based programs to document participation and behavioral and health status changes.

| Task | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
Task | N/A | In Progress | 07/01/2015 | 03/31/2018 | 03/31/2018 | DY3 Q4 |
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<th>Project Requirements (Milestone/Task Name)</th>
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<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.</td>
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<tr>
<td>Task 1. Establish agreements with community-based organizations.</td>
<td>Project</td>
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<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>Task 2. Conduct periodic training to staff on warm referral and follow-up process.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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</tr>
<tr>
<td>Task 3. Establish a process to facilitate feedback to and from community organizations.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
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<tr>
<td>Task 4. Develop a referral and follow-up process.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Task 5. Ensure adherence to CBO referral process.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Task 6. When applicable utilize electronic referrals to CBO’s from primary care offices.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<tr>
<td>Milestone #14</td>
<td>Develop and implement protocols for home blood pressure monitoring with follow up support.</td>
<td>Project</td>
<td>N/A</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>Task PPS has developed and implemented protocols for home blood pressure monitoring.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>Task PPS provides periodic training to staff on warm referral and follow-up process.</td>
<td>Project</td>
<td>In Progress</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>Task 1. Medical Management Committee to review and select nationally recognized protocols for blood pressure monitoring.</td>
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<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<tr>
<td>Task 2. Provide regular customized support and advice (e.g., medication titration, lifestyle modifications) based on patient blood pressure readings.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>09/30/2016</td>
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<tr>
<td>Task 3. Implement clinical support protocols / systems that incorporate regular transmission of patients’ home blood pressure readings and customized clinician feedback into patient care.</td>
<td>Project</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>Task 4. Train staff to administer specific clinical support interventions as available</td>
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<td>Project Requirements (Milestone/Task Name)</td>
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<td>Quarter End Date</td>
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</tr>
<tr>
<td>(e.g., telemonitoring, patient portals, counseling, Web sites).</td>
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<tr>
<td>Task 5. Incorporate regular transmission of patient home blood pressure readings through patient portals, telemonitoring, log books to clinicians and EHR systems.</td>
<td>Project</td>
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<tr>
<td>Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<tr>
<td>Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<td>03/31/2017</td>
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<tr>
<td>Task 1. Generate lists of patients with hypertension who have missed recent appointments. Send phone, mail, e-mail, or text reminders.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>06/30/2016</td>
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<tr>
<td>Task 2. Print visit summaries and follow-up guidance for patients.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
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<td>Task 3. Implement an automated or work driver scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<tr>
<td>Milestone #16 Facilitate referrals to NYS Smoker's Quitline.</td>
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<tr>
<td>Task PPS has developed referral and follow-up process and adheres to process.</td>
<td>Project</td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>Task 1. Develop a referral and follow-up process and that adheres to the 5A's process</td>
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<td>09/30/2016</td>
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<tr>
<td>Task 2. Refer Smokers to NYS Smokers Quit line through EHR/FAX</td>
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<tr>
<td>Task 3. Post smoking cessation information in waiting rooms</td>
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<tr>
<td>Task 4. Providers will establish and conduct follow-up visits</td>
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<tr>
<td>Task 5. Implement EHRs that will require providers to ask and advise patients about smoking</td>
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<tr>
<td>Milestone #17 Perform additional actions including &quot;hot spotting&quot; strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.</td>
<td>Project</td>
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<td>03/31/2018</td>
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<td>Task</td>
<td>Project</td>
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### Samaritan Medical Center (PPS ID:45)

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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>If applicable, PPS has implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.</td>
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<tr>
<td>Task</td>
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</tr>
<tr>
<td>If applicable, PPS has established linkages to health homes for targeted patient populations.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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</tr>
<tr>
<td>If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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</tr>
<tr>
<td>Task 1. Assess and Stratify population into categories.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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</tr>
<tr>
<td>Task 2. Assess and Stratify data collection population based on (Race, Ethnicity, and Language) (REAL).</td>
<td>Project</td>
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<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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</tr>
<tr>
<td>Task 3. Develop improvement processes and plans that address top health disparities and improve workflow</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<td>Task 4. Establish linkages to health homes for targeted patient populations</td>
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<td>06/30/2017</td>
<td>06/30/2017</td>
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<tr>
<td>Task 5. Implement Stanford model through partnerships with community based organizations (CBO's).</td>
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<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Task 6. Conduct training on high risk populations, Stanford Model for chronic diseases and linkages to health homes.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Milestone #18 Adopt strategies from the Million Hearts Campaign.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<td>Task</td>
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<tr>
<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<td>Task</td>
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<tr>
<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
<td>Provider</td>
<td>Non-PCP Practitioners</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
<td>Provider</td>
<td>Behavioral Health</td>
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<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
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<tr>
<td>Task 2. Adopt strategies and implement policies and procedures that reflect the</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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</table>

NYS Confidentiality – High
### Samaritan Medical Center (PPS ID:45)

- **Task**: 3. Conduct routine data assessments and produce periodic updates that demonstrate an increase in home blood pressure monitoring
  - **Reporting Level**: Project
  - **Provider Type**: N/A
  - **Status**: In Progress
  - **Start Date**: 04/01/2015
  - **End Date**: 03/31/2017
  - **Quarter End Date**: 03/31/2017
  - **DSRIP Reporting Year and Quarter**: DY2 Q4

- **Milestone #19**
  - Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.
  - **Reporting Year and Quarter**: selected principles and initiatives of the Million Hearts Campaign.

- **Task**: 1. Establish agreement’s 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.
  - **Reporting Level**: Project
  - **Provider Type**: N/A
  - **Status**: In Progress
  - **Start Date**: 07/01/2015
  - **End Date**: 03/31/2017
  - **Quarter End Date**: 03/31/2017
  - **DSRIP Reporting Year and Quarter**: DY3 Q4

- **Task**: 2. Documented evidence of agreements
  - **Reporting Level**: Project
  - **Provider Type**: N/A
  - **Status**: In Progress
  - **Start Date**: 07/01/2015
  - **End Date**: 03/31/2017
  - **Quarter End Date**: 03/31/2017
  - **DSRIP Reporting Year and Quarter**: DY3 Q4

- **Task**: Engage a majority (at least 80%) of primary care providers in this project.
  - **Reporting Level**: Project
  - **Provider Type**: Primary Care Physicians
  - **Status**: On Hold
  - **Start Date**: 04/01/2015
  - **End Date**: 03/31/2020
  - **Quarter End Date**: 03/31/2020
  - **DSRIP Reporting Year and Quarter**: DY5 Q4

- **Task**: Utilize FDRHPO Communications Committee to support communication needs
  - **Reporting Level**: Project
  - **Provider Type**: N/A
  - **Status**: In Progress
  - **Start Date**: 04/01/2015
  - **End Date**: 03/31/2016
  - **Quarter End Date**: 03/31/2016
  - **DSRIP Reporting Year and Quarter**: DY1 Q4

- **Task**: Utilize Medical Management Committee to support the engagement of PPS providers in achieving DSRIP transformation.
  - **Reporting Level**: Project
  - **Provider Type**: N/A
  - **Status**: In Progress
  - **Start Date**: 04/01/2015
  - **End Date**: 03/31/2016
  - **Quarter End Date**: 03/31/2016
  - **DSRIP Reporting Year and Quarter**: DY1 Q4

- **Task**: Identify PCP’s and gain commitment to achieve metrics associated with 3.b.i
  - **Reporting Level**: Project
  - **Provider Type**: N/A
  - **Status**: In Progress
  - **Start Date**: 04/01/2015
  - **End Date**: 03/31/2016
  - **Quarter End Date**: 03/31/2016
  - **DSRIP Reporting Year and Quarter**: DY1 Q4

- **Task**: Implement and Utilize practitioner communications engagement plan to: inform, improve, sustain two-way communications.
  - **Reporting Level**: Project
  - **Provider Type**: N/A
  - **Status**: In Progress
  - **Start Date**: 04/01/2015
  - **End Date**: 03/31/2016
  - **Quarter End Date**: 03/31/2016
  - **DSRIP Reporting Year and Quarter**: DY1 Q4

- **Task**: Evaluate organizational infrastructure and resources required to achieve metrics associated with project 3.b.i
  - **Reporting Level**: Project
  - **Provider Type**: N/A
  - **Status**: In Progress
  - **Start Date**: 04/01/2015
  - **End Date**: 06/30/2016
  - **Quarter End Date**: 06/30/2016
  - **DSRIP Reporting Year and Quarter**: DY2 Q1

- **Task**: Leverage technological infrastructure to overcome geographical distances between participating providers and to facilitate collaboration
  - **Reporting Level**: Project
  - **Provider Type**: N/A
  - **Status**: In Progress
  - **Start Date**: 04/01/2015
  - **End Date**: 03/31/2017
  - **Quarter End Date**: 03/31/2017
  - **DSRIP Reporting Year and Quarter**: DY2 Q4
### Project Requirements (Milestone/Task Name) | Reporting Level | Provider Type | Status | Start Date | End Date | Quarter | DSRIP Reporting Year and Quarter
--- | --- | --- | --- | --- | --- | --- | ---
Task 7. Generate lists of total PCP's in PPS and engage at-least 80% to participate in project. | Project | In Progress | 04/01/2015 | 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 1. Assess and Stratify population into risk categories.

Task 2. Assess and Stratify population lifestyle approaches to prevent CVD.

Task 3. Determine other CVD risk-reducing interventions and categorize by priority based on class recommendation.

Task 4. Develop a program to improve CVD that utilizes evidence-based strategies and stratified data in the ambulatory setting.

Task 5. Develop a program to improve CVD that utilizes evidence-based strategies and stratified data in community care setting.

Task 6. Conducting CVD training and awareness for population, ambulatory and community based organizations.

Task 7. Implement program to improve CVD management using evidence-based strategies in the ambulatory and community based setting.

Task 8. Monitor and control CVD program management in the ambulatory and community based settings.

**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...
## Samaritan Medical Center (PPS ID:45)

### Project Requirements

<table>
<thead>
<tr>
<th>Task</th>
<th>Milestone/Task Name</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.</td>
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<td>Task</td>
<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<tr>
<td>Task</td>
<td>EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.</td>
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<tr>
<td>Task</td>
<td>PPS uses alerts and secure messaging functionality.</td>
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<tr>
<td>Task</td>
<td>1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.</td>
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<tr>
<td>Task</td>
<td>2. Perform a gap analysis and a plan with budget to address the identified needs</td>
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<tr>
<td>Task</td>
<td>3. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
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<td>Task</td>
<td>4. During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, &amp; issues are communicated and a plan is in place to address them.</td>
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<td>Task</td>
<td>5. Perform a post-go-live gap analysis and a plan with budget to address the identified needs</td>
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<tr>
<td>Task</td>
<td>6. Facilitate the practice’s connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</td>
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<tr>
<td>Milestone #3</td>
<td>Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.</td>
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<tr>
<td>Task</td>
<td>EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated)</td>
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</tbody>
</table>
### 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
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
into the assessment criteria).  

**Task**  
PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.  
0 0 0 0 0 0 0 0 0 0

**Task**  
1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.

**Task**  
2. Perform a gap analysis and a plan with budget to address the identified needs

**Task**  
3. Perform a pre-MU and PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to attest for MU and apply for NCQA PCMH by DSRIP DY3.

**Task**  
4. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.

**Task**  
5. During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, & issues are communicated and a plan is in place to address them.

**Task**  
6. Perform a post-go-live gap analysis and a plan with budget to address the identified needs

**Task**  
7. Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.

**Task**  
8. Begin MU attestations & PCMH recognitions with prioritization based on attributed Medicaid population and provider engagement.

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

**Task**  
PSS identifies targeted patients and is able to track actively
Samaritan Medical Center (PPS ID:45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
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<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>engaged patients for project milestone reporting.</td>
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<tr>
<td>Task 1. Identify targeted patient population through data collection</td>
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<td>Task 2. Track / Monitor actively engaged patients utilizing designated tracking systems</td>
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<td>Task 3. Report actively engaged patients against milestone completion</td>
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<td>Task 4. Routinely Measure outcomes through quality assessment</td>
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<tr>
<td><strong>Milestone #5</strong> Use the EHR to prompt providers to complete the 5 A’s of tobacco control (Ask, Assess, Advise, Assist, and Arrange).</td>
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<td>Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.</td>
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<tr>
<td>Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A’s of tobacco control.</td>
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<tr>
<td>Task 1. Assess EMR systems limitations and capabilities for incorporation of 5A’s</td>
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<td>Task 2. Promote direct conversation of 5A’s between patient /clinician</td>
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<tr>
<td>Task 3. Identify and Stratify population into tobacco use and non-tobacco categories.</td>
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<td>Task 4. Formulate data collection to create patient tobacco use listings</td>
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<td>Task 5. Train staff to incorporate EHR to prompt the use of 5A’s of tobacco control</td>
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<td>Task 6. Implement an automated or work driver scheduling system to facilitate tobacco control protocols.</td>
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<tr>
<td>Task 7. Practitioners and Clinics document in EHR system patient tobacco use status</td>
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<tr>
<td><strong>Milestone #6</strong> Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.</td>
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## Project Requirements (Milestone/Task Name)  

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<thead>
<tr>
<th>Task</th>
<th><strong>DY1,Q1</strong></th>
<th><strong>DY1,Q2</strong></th>
<th><strong>DY1,Q3</strong></th>
<th><strong>DY1,Q4</strong></th>
<th><strong>DY2,Q1</strong></th>
<th><strong>DY2,Q2</strong></th>
<th><strong>DY2,Q3</strong></th>
<th><strong>DY2,Q4</strong></th>
<th><strong>DY3,Q1</strong></th>
<th><strong>DY3,Q2</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).</strong></td>
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<tr>
<td><strong>Task 1. Practices will provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</strong></td>
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<td><strong>Task 2. Make hypertension control a priority in practices and health systems and identify the protocol's in achieving control of blood pressure for hypertensive patients.</strong></td>
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<td><strong>Task 3. Identify patients who have repeated elevated blood pressure readings in their medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.</strong></td>
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<td><strong>Task 4. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</strong></td>
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<td><strong>Task 5. Provide training to ensure attainment of correct blood pressure measurements.</strong></td>
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<td><strong>Task 6. Conduct pre-visit planning to ensure blood pressure is a focus of patient visits.</strong></td>
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<td><strong>Task 7. Incorporate coaching and self-management into patient educations and follow-up visits.</strong></td>
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<td><strong>Task 8. Practices will adopt treatment protocols that align with national guidelines: US Preventive Task Force (USPSTF) or National Cholesterol Education Program (NCEP).</strong></td>
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<td><strong>Milestone #7</strong></td>
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<td><strong>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.</strong></td>
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<td><strong>Task</strong></td>
<td><strong>Clinically Interoperable System is in place for all participating providers.</strong></td>
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<td><strong>Task</strong></td>
<td><strong>Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health</strong></td>
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<td>Home care managers where applicable.</td>
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<td><strong>Task</strong> 1. Form care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers.</td>
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<td><strong>Task</strong> 2. Implement care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
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<td><strong>Task</strong> 3. Validate care coordination processes are in place.</td>
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<td><strong>Task</strong> 4. All participating providers will have a Clinically Interoperable System in place.</td>
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<td><strong>Milestone #8</strong> Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
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<td><strong>Task</strong> All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.</td>
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<td><strong>Task</strong> 1. Provide patient training to ensure attainment of correct blood pressure measurements</td>
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<td><strong>Task</strong> 2. Practices will provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
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<td><strong>Task</strong> 3. Incorporate coaching and self-management into patient education and follow-up visits</td>
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<td><strong>Milestone #9</strong> Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.</td>
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<td><strong>Task</strong> PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.</td>
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<td><strong>Task</strong> 1. Conduct training to ensure attainment of correct blood pressure measurements</td>
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<td><strong>Task</strong> 2. Document blood pressure readings in EMR system</td>
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### Samaritan Medical Center (PPS ID:45)

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<th>DY3,Q1</th>
<th>DY3,Q2</th>
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</thead>
<tbody>
<tr>
<td><strong>Task</strong> 3. Conduct annual assessment and attestation of health care staffs understanding of correct blood pressure measurement techniques and equipment.</td>
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<td><strong>Milestone #10</strong> Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.</td>
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<td><strong>Task</strong> PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.</td>
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<td><strong>Task</strong> PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<td><strong>Task</strong> PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.</td>
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<td><strong>Task</strong> 1. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<td><strong>Task</strong> 2. Make hypertension control a priority in practices and health systems and identify the protocol’s in achieving control of blood pressure for hypertensive patients</td>
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<td><strong>Task</strong> 3. Conduct pre-visit planning to ensure blood pressure is a focus of patient visits</td>
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<td><strong>Milestone #11</strong> Prescribe once-daily regimens or fixed-dose combination pills when appropriate.</td>
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<td><strong>Task</strong> PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.</td>
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<td><strong>Task</strong> 1. Encourage patients to use medication reminders.</td>
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<td><strong>Task</strong> 2. Ensure patients understand their risks if they do not take medications as directed.</td>
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<td><strong>Task</strong> 3. Confirm medication benefits with patients.</td>
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<td><strong>Task</strong> 4. Educate patients on the use of medication reminders.</td>
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NYS Confidentiality – High
## Project Requirements

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<td>5. Implement protocols for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.</td>
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<td>6. Provide once daily regimens or fixed-dosed combination pills when appropriate.</td>
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<td>7. Conduct frequent / routine follow-ups with patients</td>
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<td><strong>Milestone #12</strong></td>
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<td>Document patient driven self-management goals in the medical record and review with patients at each visit.</td>
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<td>Self-management goals are documented in the clinical record.</td>
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<td>PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.</td>
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<tr>
<td>1. Print visit summaries and follow-up guidance for patients.</td>
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<td>2. Generate lists of patients with hypertension who have missed recent appointments. Send phone, mail, e-mail, or text reminders.</td>
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<td>3. Provide patients who have hypertension with a written self-management plan at the end of each office visit.</td>
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<td>4. Encourage or provide patient support groups.</td>
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<td>5. Use all staff interactions with patients as opportunities to assist in self-management goal-setting and practices</td>
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<td>Follow up with referrals to community based programs to document participation and behavioral and health status changes.</td>
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<td>PPS has developed referral and follow-up process and adheres to process.</td>
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<td>PPS provides periodic training to staff on warm referral and follow-up process.</td>
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<td>Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.</td>
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NYS Confidentiality – High
## Project Requirements

**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**<br>1. Establish agreements with community-based organizations.<br>2. Conduct periodic training to staff on warm referral and follow-up process.<br>3. Establish a process to facilitate feedback to and from community organizations.<br>4. Develop a referral and follow-up process.<br>5. Ensure adherence to CBO referral process.<br>6. When applicable utilize electronic referrals to CBO’s from primary care offices.<br>Milestone #14<br>Develop and implement protocols for home blood pressure monitoring with follow up support.<br>Milestone #14<br>PPS has developed and implemented protocols for home blood pressure monitoring.<br>Milestone #14<br>PPS provides follow up to support patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.<br>Milestone #14<br>PPS provides periodic training to staff on warm referral and follow-up process.<br>1. Medical Management Committee to review and select nationally recognized protocols for blood pressure monitoring.<br>2. Provide regular customized support and advice (e.g., medication titration, lifestyle modifications) based on patient blood pressure readings.<br>3. Implement clinical support protocols / systems that incorporate regular transmission of patients’ home blood pressure readings and customized clinician feedback into patient care.<br>4. Train staff to administer specific clinical support interventions as available (e.g., telemonitoring, patient portals, counseling, Web sites).
**Samaritan Medical Center (PPS ID:45)**

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<th>Project Requirements (Milestone/Task Name)</th>
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<tbody>
<tr>
<td>Task 5. Incorporate regular transmission of patient home blood pressure readings through patient portals, telemonitoring, log books to clinicians and EHR systems.</td>
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<td><strong>Milestone #15</strong> Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<td>Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<td>Task 1. Generate lists of patients with hypertension who have missed recent appointments. Send phone, mail, e-mail, or text reminders.</td>
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<td>Task 2. Print visit summaries and follow-up guidance for patients.</td>
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<td>Task 3. Implement an automated or work driver scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<td><strong>Milestone #16</strong> Facilitate referrals to NYS Smoker's Quitline.</td>
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<td>Task PPS has developed referral and follow-up process and adheres to process.</td>
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<td>Task 1. Develop a referral and follow-up process and that adheres to the 5A's process</td>
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<td>Task 2. Refer Smokers to NYS Smokers Quitline through EHR/FAX</td>
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<td>Task 3. Post smoking cessation information in waiting rooms</td>
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<td>Task 4. Providers will establish and conduct follow-up visits</td>
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<td>Task 5. Implement EHRs that will require providers to ask and advise patients about smoking</td>
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<td><strong>Milestone #17</strong> Perform additional actions including &quot;hot spotting&quot; strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.</td>
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<td>Task If applicable, PPS has implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement</td>
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<td>If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.</td>
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<td>2. Assess and Stratify data collection population based on (Race, Ethnicity, and Language) (REAL).</td>
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<td>3. Develop improvement processes and plans that address top health disparities and improve workflow</td>
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<td>5. Implement Stanford model through partnerships with community based organizations (CBO's).</td>
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<td>6. Conduct training on high risk populations, Stanford Model for chronic diseases and linkages to health homes.</td>
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<td>1. Baseline and stratify data for home blood pressure monitoring.</td>
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<td>2. Adopt strategies and implement policies and procedures that reflect the selected principles and initiatives of the Million Hearts Campaign.</td>
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<td>3. Conduct routine data assessments and produce periodic updates that demonstrate an increase in home blood pressure monitoring</td>
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<td>Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.</td>
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<td>PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
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<td>1. Establish agreement's with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
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<td>2. Documented evidence of agreements</td>
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<td>Engage a majority (at least 80%) of primary care providers in this project.</td>
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<td>PPS has engaged at least 80% of their PCPs in this activity.</td>
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<td>1. Utilize FDRHPO Communications Committee to support communication needs</td>
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<td>2. Utilize Medical Management Committee to support the engagement of PPS providers in achieving DSRIP transformation.</td>
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<td>3. Identify PCP’s and gain commitment to achieve metrics associated with 3.b.i</td>
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<td>4. Implement and Utilize practitioner communications engagement plan to: inform, improve, sustain two-way communications.</td>
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<td>5. Evaluate organizational infrastructure and resources required to achieve metrics associated with project 3.b.i</td>
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NYS Confidentiality – High
## Samaritan Medical Center (PPS ID:45)

### Task 6. Leverage technological infrastructure to overcome geographical distances between participating providers and to facilitate collaboration

### Task 7. Generate lists of total PCP's in PPS and engage at least 80% to participate in project.

### Milestone #1
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.

- **Task 1.** Assess and stratify population into risk categories.
- **Task 2.** Assess and stratify population lifestyle approaches to prevent CVD.
- **Task 3.** Determine other CVD risk-reducing interventions and categorize by priority based on class recommendation.
- **Task 4.** Develop a program to improve CVD that utilizes evidence-based strategies and stratified data in the ambulatory setting.
- **Task 5.** Develop a program to improve CVD that utilizes evidence-based strategies and stratified data in community care setting.
- **Task 6.** Conducting CVD training and awareness for population, ambulatory and community-based organizations.
- **Task 7.** Implement program to improve CVD management using evidence-based strategies in the ambulatory and community-based setting.
- **Task 8.** Monitor and control CVD program management in the ambulatory and community-based settings.

### Milestone #2
Ensure that all PPS safety net providers are actively connected.

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

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<th>DY5,Q4</th>
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<tr>
<td>to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.</td>
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<td>Task PPS uses alerts and secure messaging functionality.</td>
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<td>Task 3. Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
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<td>Task 5. Perform a post-go-live gap analysis and a plan with budget to address the identified needs</td>
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<td>Task 6. Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</td>
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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.
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<th>Project Requirements (Milestone/Task Name)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
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<td>Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
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<td>Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
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<td>Task 3. Perform a pre-MU and PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to attest for MU and apply for NCQA PCMH by DSRIP DY3.</td>
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<td>Task 8. Begin MU attestations &amp; PCMH recognitions with prioritization based on attributed Medicaid population and provider engagement.</td>
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<td>Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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## Project Requirements

### (Milestone/Task Name)

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<tr>
<th>Task</th>
<th>Project Requirements</th>
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<tbody>
<tr>
<td><strong>PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</strong></td>
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<tr>
<td><strong>Task</strong></td>
<td>Identify targeted patient population through data collection</td>
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<td><strong>Task</strong></td>
<td>Track / Monitor actively engaged patients utilizing designated tracking systems</td>
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<td><strong>Task</strong></td>
<td>Report actively engaged patients against milestone completion</td>
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<tr>
<td><strong>Task</strong></td>
<td>Routinely Measure outcomes through quality assessment</td>
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<tr>
<td><strong>Milestone #5</strong></td>
<td>Use the EHR to prompt providers to complete the 5 A’s of tobacco control (Ask, Assess, Advise, Assist, and Arrange).</td>
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<tr>
<td><strong>Task</strong></td>
<td>PPS has implemented an automated scheduling system to facilitate tobacco control protocols.</td>
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<td><strong>Task</strong></td>
<td>PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A’s of tobacco control.</td>
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<td><strong>Task</strong></td>
<td>Assess EMR systems limitations and capabilities for incorporation of 5A’s</td>
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<td><strong>Task</strong></td>
<td>Promote direct conversation of 5A’s between patient /clinician</td>
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<td><strong>Task</strong></td>
<td>Identify and Stratify population into tobacco use and non-tobacco categories.</td>
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<td><strong>Task</strong></td>
<td>Formulate data collection to create patient tobacco use listings</td>
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<td><strong>Task</strong></td>
<td>Train staff to incorporate EHR to prompt the use of 5A’s of tobacco control</td>
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<td><strong>Task</strong></td>
<td>Implement an automated or work driver scheduling system to facilitate tobacco control protocols.</td>
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<tr>
<td><strong>Task</strong></td>
<td>Practioners and Clinics document in EHR system patient tobacco use status</td>
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<tr>
<td><strong>Milestone #6</strong></td>
<td>Adopt and follow standardized treatment protocols for</td>
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### Project Requirements (Milestone/Task Name)

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<th>Task</th>
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<tr>
<td>Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).</td>
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<td>1. Practices will provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
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<td>2. Make hypertension control a priority in practices and health systems and identify the protocol's in achieving control of blood pressure for hypertensive patients</td>
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<td>3. Identify patients who have repeated elevated blood pressure readings in their medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.</td>
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<td>4. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<td>5. Provide training to ensure attainment of correct blood pressure measurements</td>
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<td>6. Conduct pre-visit planning to ensure blood pressure is a focus of patient visits</td>
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<td>7. Incorporate coaching and self-management into patient educations and follow-up visits</td>
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<td>8. Practices will adopt treatment protocols that align with national guidelines: US Preventive Task Force (USPSTF) or National Cholesterol Education Program (NCEP)</td>
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<td>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.</td>
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<td>Task: Clinically Interoperable System is in place for all participating providers.</td>
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<td>Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
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<td>Care coordination processes are in place.</td>
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<td>1. Form care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers.</td>
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<td>2. Implement care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
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<td>3. Validate Care coordination processes are in place.</td>
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<td>4. All participating providers will have a Clinically Interoperable System in place</td>
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<td>Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
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<td>All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.</td>
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<td>1. Provide patient training to ensure attainment of correct blood pressure measurements</td>
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<td>2. Practices will provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
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<td>3. Incorporate coaching and self-management into patient educations and follow-up visits</td>
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<td>Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.</td>
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<td>PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.</td>
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NYS Confidentiality – High
# Project Requirements (Milestone/Task Name)

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<tbody>
<tr>
<td>2. Document blood pressure readings in EMR system</td>
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<td>3. Conduct annual assessment and attestation of health care staffs understanding of correct blood pressure measurement techniques and equipment.</td>
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<tr>
<td><strong>Milestone #10</strong> Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.</td>
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<td>Task</td>
<td>PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.</td>
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<td>Task</td>
<td>PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<td>PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.</td>
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<td>Task</td>
<td>1. Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<td>Task</td>
<td>2. Make hypertension control a priority in practices and health systems and identify the protocol’s in achieving control of blood pressure for hypertensive patients</td>
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<td>Task</td>
<td>3. Conduct pre-visit planning to ensure blood pressure is a focus of patient visits</td>
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<td><strong>Milestone #11</strong> Prescribe once-daily regimens or fixed-dose combination pills when appropriate.</td>
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<td>Task</td>
<td>PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.</td>
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<td>Task</td>
<td>1. Encourage patients to use medication reminders.</td>
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<td>2. Ensure patients understand their risks if they do not take medications as directed.</td>
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<td>Task</td>
<td>3. Confirm medication benefits with patients.</td>
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<td>4. Educate patients on the use of medication reminders.</td>
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<td>5. Implement protocols for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.</td>
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<td>6. Provide once daily regimens or fixed-dosed combination pills when appropriate.</td>
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<td>7. Conduct frequent/routine follow-ups with patients</td>
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<td>Document patient driven self-management goals in the medical record and review with patients at each visit.</td>
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<td>Self-management goals are documented in the clinical record.</td>
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<td>PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.</td>
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<td>1. Print visit summaries and follow-up guidance for patients.</td>
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<td>2. Generate lists of patients with hypertension who have missed recent appointments. Send phone, mail, e-mail, or text reminders.</td>
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<td>3. Provide patients who have hypertension with a written self-management plan at the end of each office visit.</td>
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<td>4. Encourage or provide patient support groups.</td>
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<td>5. Use all staff interactions with patients as opportunities to assist in self-management goal-setting and practices</td>
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<td>Follow up with referrals to community based programs to document participation and behavioral and health status changes.</td>
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<td>PPS has developed referral and follow-up process and adheres to process.</td>
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<td>PPS provides periodic training to staff on warm referral and follow-up process.</td>
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<td>Agreements are in place with community-based organizations</td>
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**NYS Confidentiality – High**
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<td>and process is in place to facilitate feedback to and from community organizations.</td>
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<td>1. Establish agreements with community-based organizations.</td>
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<td>2. Conduct periodic training to staff on warm referral and follow-up process.</td>
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<td>3. Establish a process to facilitate feedback to and from community organizations.</td>
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<td>4. Develop a referral and follow-up process.</td>
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<td>5. Ensure adherence to CBO referral process.</td>
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<td>6. When applicable utilize electronic referrals to CBO's from primary care offices.</td>
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<td>Develop and implement protocols for home blood pressure monitoring with follow up support.</td>
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<td>PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.</td>
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<td>PPS provides periodic training to staff on warm referral and follow-up process.</td>
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<td>1. Medical Management Committee to review and select nationally recognized protocols for blood pressure monitoring.</td>
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<td>2. Provide regular customized support and advice (e.g., medication titration, lifestyle modifications) based on patient blood pressure readings.</td>
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<td>3. Implement clinical support protocols / systems that incorporate regular transmission of patients' home blood pressure readings and customized clinician feedback into patient care.</td>
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<td>4. Train staff to administer specific clinical support interventions as available (e.g., telemonitoring, patient portals, counseling.</td>
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NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

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<td>5. Incorporate regular transmission of patient home blood pressure readings through patient portals, telemonitoring, log books to clinicians and EHR systems.</td>
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<td>Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
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<td>PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<tr>
<td>1. Generate lists of patients with hypertension who have missed recent appointments. Send phone, mail, e-mail, or text reminders.</td>
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<td>2. Print visit summaries and follow-up guidance for patients.</td>
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<td>3. Implement an automated or work driver scheduling system to facilitate scheduling of targeted hypertension patients.</td>
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<td>Facilitate referrals to NYS Smoker's Quitline.</td>
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<td>PPS has developed referral and follow-up process and adheres to process.</td>
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<tr>
<td>1. Develop a referral and follow-up process and that adheres to the 5A's process</td>
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<td>2. Refer Smokers to NYS Smokers Quit line through EHR/FAX</td>
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<td>3. Post smoking cessation information in waiting rooms</td>
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<td>4. Providers will establish and conduct follow-up visits</td>
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<td>5. Implement EHRs that will require providers to ask and advise patients about smoking</td>
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<td>Perform additional actions including “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.</td>
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<td>If applicable, PPS has implemented collection of valid and</td>
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NYS Confidentiality – High
### Project Requirements (Milestone/Task Name)

<table>
<thead>
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<th>Task</th>
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<th>DY5,Q2</th>
<th>DY5,Q3</th>
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<tbody>
<tr>
<td>1.</td>
<td>Baseline and stratify data for home blood pressure monitoring.</td>
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<td>2.</td>
<td>Adopt strategies and implement policies and procedures that reflect principles and initiatives of Million Hearts Campaign.</td>
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<td>3.</td>
<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
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<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
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<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
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<td>6.</td>
<td>Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.</td>
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### Samaritan Medical Center (PPS ID:45)

- **Project Requirements**
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  - DY3,Q4
  - DY4,Q1
  - DY4,Q2
  - DY4,Q3
  - DY4,Q4
  - DY5,Q1
  - DY5,Q2
  - DY5,Q3
  - DY5,Q4

- **Task 1. Assess and Stratify population into categories.**
- **Task 2. Assess and Stratify data collection population based on (Race, Ethnicity, and Language) (REAL).**
- **Task 3. Develop improvement processes and plans that address top health disparities and improve workflow.**
- **Task 4. Establish linkages to health homes for targeted patient populations.**
- **Task 5. Implement Stanford model through partnerships with community based organizations (CBO’s).**
- **Task 6. Conduct training on high risk populations, Stanford Model for chronic diseases and linkages to health homes.**

### Milestone #18

- **Adopt strategies from the Million Hearts Campaign.**
  - Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.  
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  - 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 0 0
  - 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 0 0

- **Task 1. Baseline and stratify data for home blood pressure monitoring.**
- **Task 2. Adopt strategies and implement policies and procedures that reflect principles and initiatives of Million Hearts Campaign.**

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*NYS Confidentiality – High*
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<tr>
<th>Project Requirements (Milestone/Task Name)</th>
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<th>DY5,Q2</th>
<th>DY5,Q3</th>
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<tr>
<td>reflect the selected principles and initiatives of the Million Hearts Campaign.</td>
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<tr>
<td><strong>Task</strong> 3. Conduct routine data assessments and produce periodic updates that demonstrate an increase in home blood pressure monitoring</td>
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<td><strong>Milestone #19</strong> Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.</td>
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<tr>
<td><strong>Task</strong> PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
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<tr>
<td><strong>Task</strong> 1. Establish agreements with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
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<td><strong>Task</strong> 2. Documented evidence of agreements</td>
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<td><strong>Milestone #20</strong> Engage a majority (at least 80%) of primary care providers in this project.</td>
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<tr>
<td><strong>Task</strong> PPS has engaged at least 80% of their PCPs in this activity.</td>
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<tr>
<td><strong>Task</strong> 1. Utilize FDRHPO Communications Committee to support communication needs</td>
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<td><strong>Task</strong> 2. Utilize Medical Management Committee to support the engagement of PPS providers in achieving DSRIP transformation.</td>
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<td><strong>Task</strong> 3. Identify PCP’s and gain commitment to achieve metrics associated with 3.b.i</td>
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<td><strong>Task</strong> 4. Implement and Utilize practitioner communications engagement plan to: inform, improve, sustain two-way communications.</td>
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<td><strong>Task</strong> 5. Evaluate organizational infrastructure and resources required to achieve metrics associated with project 3.b.i</td>
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NYS Confidentiality – High
## Project Requirements (Milestone/Task Name)

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<tr>
<td>6.</td>
<td>Leverage technological infrastructure to overcome geographical distances between participating providers and to facilitate collaboration</td>
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<td>7.</td>
<td>Generate lists of total PCP's in PPS and engage at-least 80% to participate in project.</td>
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### Prescribed Milestones Current File Uploads

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<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
<th>Upload Date</th>
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### Prescribed Milestones Narrative Text

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<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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<tbody>
<tr>
<td>Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.</td>
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<tr>
<td>Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.</td>
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<tr>
<td>Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.</td>
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<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<td>Use the EHR to prompt providers to complete the 5 A’s of tobacco control (Ask, Assess, Advise, Assist, and Arrange).</td>
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<tr>
<td>Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.</td>
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<td>Narrative Text</td>
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<tr>
<td>Develop care coordination teams including use of nursing staff, pharmacists,</td>
<td>Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.</td>
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<tr>
<td>dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.</td>
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<tr>
<td>Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
<td>Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.</td>
</tr>
<tr>
<td>Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.</td>
<td>Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.</td>
</tr>
<tr>
<td>Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.</td>
<td>Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.</td>
</tr>
<tr>
<td>Prescribe once-daily regimens or fixed-dose combination pills when appropriate.</td>
<td>Prescribe once-daily regimens or fixed-dose combination pills when appropriate.</td>
</tr>
<tr>
<td>Document patient driven self-management goals in the medical record and review with patients at each visit.</td>
<td>Document patient driven self-management goals in the medical record and review with patients at each visit.</td>
</tr>
<tr>
<td>Follow up with referrals to community based programs to document participation and behavioral and health status changes.</td>
<td>Follow up with referrals to community based programs to document participation and behavioral and health status changes.</td>
</tr>
<tr>
<td>Develop and implement protocols for home blood pressure monitoring with follow up support.</td>
<td>Develop and implement protocols for home blood pressure monitoring with follow up support.</td>
</tr>
<tr>
<td>Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
<td>Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.</td>
</tr>
<tr>
<td>Facilitate referrals to NYS Smoker's Quitline.</td>
<td>Facilitate referrals to NYS Smoker's Quitline.</td>
</tr>
<tr>
<td>Perform additional actions including “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.</td>
<td>Perform additional actions including “hot spotting” strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.</td>
</tr>
<tr>
<td>Adopt strategies from the Million Hearts Campaign.</td>
<td>Adopt strategies from the Million Hearts Campaign.</td>
</tr>
<tr>
<td>Milestone Name</td>
<td>Narrative Text</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.</td>
<td></td>
</tr>
<tr>
<td>Engage a majority (at least 80%) of primary care providers in this project.</td>
<td></td>
</tr>
</tbody>
</table>
IPQR Module 3.b.i.5 - PPS Defined Milestones

Instructions:

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

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

No Records Found

PPS Defined Milestones Current File Uploads

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<th>Milestone Name</th>
<th>User ID</th>
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<th>Description</th>
<th>Upload Date</th>
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No Records Found

PPS Defined Milestones Narrative Text

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

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

Instructions:
Project 3.c.i – Evidence-based strategies for disease management in high risk/affected populations (adults only)

**IPQR Module 3.c.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.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.) Risk: Changing the behavior of Medicaid patients.</td>
<td>a.) Establishing a schedule for community outreach and creating awareness on services and supports available. b.) Providing health literacy and competency training for members providing care.</td>
</tr>
<tr>
<td>2.) Risk: Adding clinical decision support into EMR systems</td>
<td>a.) A plan has been established to not turn on all CDS, just those that impact the evidence based guidelines chosen. b.) HIT implementation specialist will work with office to assist in the proper use of CDS</td>
</tr>
<tr>
<td>3.) Risk: Adoption of PCMH 2014 standards</td>
<td>a.) PCMH certified content experts will be deployed to assist offices in obtaining PCMH level 3 2014 certification.</td>
</tr>
<tr>
<td>4.) Risk: Only three Certified Diabetes Educators (CDEs) across entire PPS geography and remote clinic locations</td>
<td>a.) The PPS has included Telemedical equipment to deployed across the PPS Provider is the Capital Application to ensure remote video access to CDE for PCMH Teams</td>
</tr>
<tr>
<td>5.) Risk: Existing provider gaps and access to care issues</td>
<td>a.) The workforce committee has established a plan for recruitment and retention of new provider's b.) Enhancements to GME program c.) Care coordination to assist the chronically ill with access to care.</td>
</tr>
</tbody>
</table>
### IPQR Module 3.c.i.2 - Project Implementation Speed

**Instructions:**

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year, Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year, Quarter (DY3,Q3 – DY5,Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td>47</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-PCP Practitioners</td>
<td>91</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinics</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Health Home / Care Management</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>19</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>24</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>197</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent Committed Providers(%)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
# Samaritan Medical Center (PPS ID: 45)

## Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year, Quarter (DY3, Q3 – DY5, Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>DY3, Q3</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>24</td>
<td>0</td>
</tr>
</tbody>
</table>

### Total Committed Providers

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year, Quarter (DY3, Q3 – DY5, Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>197</td>
<td>0</td>
</tr>
</tbody>
</table>

### Percent Committed Providers (%)

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year, Quarter (DY3, Q3 – DY5, Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.00</td>
<td>0</td>
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## Current File Uploads

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<tr>
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<th>File Description</th>
<th>Upload Date</th>
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No Records Found

### Narrative Text:

NYS Confidentiality – High
### IPQR Module 3.c.i.3 - Patient Engagement Speed

**Instructions:**

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

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
<th>DY1,Q3</th>
<th>DY1,Q4</th>
<th>DY2,Q1</th>
<th>DY2,Q2</th>
<th>DY2,Q3</th>
<th>DY2,Q4</th>
<th>DY3,Q1</th>
<th>DY3,Q2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>315</td>
<td>473</td>
<td>631</td>
<td>473</td>
<td>946</td>
<td>1,262</td>
<td>1,578</td>
<td>700</td>
<td>1,400</td>
</tr>
<tr>
<td>Percent of Expected Engagement</td>
<td>0.00</td>
<td>11.25</td>
<td>16.89</td>
<td>22.54</td>
<td>16.89</td>
<td>33.79</td>
<td>45.07</td>
<td>56.36</td>
<td>25.00</td>
<td>50.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
<th>DY3,Q3</th>
<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>2,100</td>
<td>2,800</td>
<td>700</td>
<td>1,400</td>
<td>2,100</td>
<td>2,800</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent of Expected Engagement</td>
<td>75.00</td>
<td>100.00</td>
<td>25.00</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
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**Current File Uploads**

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

**Narrative Text:**
**IPQR Module 3.c.i.4 - Prescribed Milestones**

Instructions:

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

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone #1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 1. Develop/Select Evidence-based strategies for the management and control of diabetes for all participating providers.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 2. Develop training materials and conduct staff training for disease management</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
<td></td>
</tr>
<tr>
<td>Task 3. Develop and Implement protocols for disease management.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2017</td>
<td>09/30/2017</td>
<td>DY3 Q2</td>
<td></td>
</tr>
<tr>
<td>Task 4. Implement Evidence-based strategies for the management and control of diabetes for all participating providers.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
<td></td>
</tr>
<tr>
<td><strong>Milestone #2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPS has engaged at least 80% of their PCPs in this activity.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
<td>On Hold</td>
<td>04/01/2015</td>
<td>03/31/2020</td>
<td>03/31/2020</td>
<td>DY5 Q4</td>
</tr>
<tr>
<td>Task 1. Evaluate organizational infrastructure and resources required to achieve metrics associated with project 3.c.i</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 2. Utilize FDRHPO Communications Committee to support communication needs</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
</tr>
<tr>
<td>Task 3. Utilize Medical Management Committee to support the engagement of PPS</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
<td></td>
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</table>
Samaritan Medical Center (PPS ID: 45)

<table>
<thead>
<tr>
<th>Project Requirements (Milestone/Task Name)</th>
<th>Reporting Level</th>
<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>providers in achieving DSRIP transformation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Task</strong> 4. Indentify PCP’s and gain commitment to achieve metrics associated with 3.c.i</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 5. Implement and Utilize practitioner communications engagement plan to: inform, improve, sustain two-way communications.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 6. Leverage technological infrastructure to overcome geographical distances between participating providers and to facilitate collaboration</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 7. Generate lists of total PCP’s in PPS and engage at-least 80% to participate in project.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Milestone #3</strong> Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Clinically Interoperable System is in place for all participating providers.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> Care coordination processes are established and implemented.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 1. Form care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> 2. All participating providers will have a Clinically Interoperable System in place</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task</strong> 3. Implement care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 4. Validate care coordination processes are in place.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Milestone #4</strong> Develop “hot spotting” strategies, in concert with Health Homes, to implement</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Project Requirements (Milestone/Task Name)</td>
<td>Reporting Level</td>
<td>Provider Type</td>
<td>Status</td>
<td>Start Date</td>
<td>End Date</td>
<td>Quarter End Date</td>
<td>DSRIP Reporting Year and Quarter</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-------------</td>
<td>--------------</td>
<td>------------</td>
<td>------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>programs such as the Stanford Model for chronic diseases in high risk neighborhoods.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If applicable, PPS has implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.</td>
<td>Project</td>
<td></td>
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<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>If applicable, PPS has established linkages to health homes for targeted patient populations.</td>
<td>Project</td>
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<tr>
<td>If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.</td>
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<tr>
<td>1. Develop improvement processes and plans that address top health disparities and improve workflow</td>
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<td>2. Assess and Stratify population into risk categories.</td>
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<td>3. Assess and Stratify data collection population based on (Race, Ethnicity, and Language) (REAL).</td>
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<td>4. Establish linkages to health homes for targeted patient populations</td>
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<tr>
<td>5. Implement Stanford model through partnerships with community based organizations (CBO’s).</td>
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<tr>
<td>6. Conduct training on high risk populations, Stanford Model for chronic diseases and linkages to health homes.</td>
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<td>Ensure coordination with the Medicaid Managed Care organizations serving the target population.</td>
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<tr>
<td>PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
<td>Project</td>
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<tr>
<td>1. Establish agreement’s with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening,</td>
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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID: 45)

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<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tr>
<td>cholesterol screening, and other preventive services relevant to this project.</td>
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<tr>
<td><strong>Task</strong> 2. Documented evidence of agreements</td>
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<td>03/31/2018</td>
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<td>DY3 Q4</td>
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<tr>
<td><strong>Milestone #6</strong> Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<td>03/31/2017</td>
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<tr>
<td><strong>Task</strong> PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
<td>Project</td>
<td></td>
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<tr>
<td><strong>Task</strong> PPS uses a recall system that allows staff to report which patients are overdue for which preventive services and to track when and how patients were notified of needed services.</td>
<td>Project</td>
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<tr>
<td><strong>Task</strong> 1. Identify and Stratify targeted patients and track actively engaged patients for project milestone reporting.</td>
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<tr>
<td><strong>Task</strong> 2. Establish and utilize a recall system that allows staff to report which patients are overdue for which preventive services and track when and how patients were notified of needed services.</td>
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<tr>
<td><strong>Task</strong> 3. Compile sample data collection of recall system and EHR completeness report to track project implementation and progress. (Recall Rosters, Roster of Identified Patients, Screenshots of Recall System)</td>
<td>Project</td>
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<tr>
<td><strong>Milestone #7</strong> Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.</td>
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<td>03/31/2018</td>
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<td>DY3 Q4</td>
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<tr>
<td><strong>Task</strong> EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
<td>Project</td>
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<td>03/31/2018</td>
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<tr>
<td><strong>Task</strong> PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.</td>
<td>Provider</td>
<td>Primary Care Physicians</td>
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<td>03/31/2020</td>
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<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Primary Care Physicians</td>
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<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
<td>Provider</td>
<td>Safety Net Non-PCP Practitioners</td>
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<tr>
<td><strong>Task</strong> EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
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### New York State Department Of Health
#### Delivery System Reform Incentive Payment Project
##### DSRIP Implementation Plan Project

**Samaritan Medical Center (PPS ID:45)**

<table>
<thead>
<tr>
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<tr>
<td>EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
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<td>Task 1. EHR meets Meaningful Use Stage 2 CMS requirements (NOTE: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).</td>
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<tr>
<td>Task 2. PPS has achieved NCQA 2014 level 3 PCMH standards and/or APCM.</td>
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<td>Task 3. EHR meets connectivity to RHIO/SHIN-NY requirements.</td>
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<td>03/31/2018</td>
<td>DY3 Q4</td>
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</table>

### EHR meets connectivity to RHIO/SHIN-NY requirements.

#### Milestone #1
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.

**Task**
Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.

**Task 1.** Develop/Select Evidence-based strategies for the management and control of diabetes for all participating providers.

**Task 2.** Develop training materials and conduct staff training for disease management

**Task 3.** Develop and Implement protocols for disease management.

**Task 4.** Implement Evidence-based strategies for the management and control of diabetes for all participating providers.

#### Milestone #2
Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.

**Task**
PPS has engaged at least 80% of their PCPs in this activity.

**Task 1.** Evaluate organizational infrastructure and resources required

---

NYS Confidentiality – High
## Project Requirements

<table>
<thead>
<tr>
<th>(Milestone/Task Name)</th>
<th>DY1,Q1</th>
<th>DY1,Q2</th>
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<tr>
<td>2. Utilize FDRHPO Communications Committee to support communication needs</td>
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<tr>
<td>3. Utilize Medical Management Committee to support the engagement of PPS providers in achieving DSRIP transformation.</td>
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<td>4. Identify PCP’s and gain commitment to achieve metrics associated with 3.c.i</td>
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<td>5. Implement and Utilize practitioner communications engagement plan to: inform, improve, sustain two-way communications.</td>
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<td>6. Leverage technological infrastructure to overcome geographical distances between participating providers and to facilitate collaboration</td>
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<td>7. Generate lists of total PCP’s in PPS and engage at-least 80% to participate in project.</td>
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<tr>
<td>Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.</td>
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<tr>
<td>Clinically Interoperable System is in place for all participating providers.</td>
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<tr>
<td>Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
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<td>Care coordination processes are established and implemented.</td>
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<tr>
<td>1. Form care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers.</td>
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<td>2. All participating providers will have a Clinically Interoperable System in place.</td>
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### Samaritan Medical Center (PPS ID:45)

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<th>DY3,Q1</th>
<th>DY3,Q2</th>
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<tbody>
<tr>
<td><strong>Task 3.</strong> Implement care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.</td>
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<td><strong>Task 4.</strong> Validate care coordination processes are in place.</td>
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<tr>
<td><strong>Milestone #4</strong> Develop &quot;hot spotting&quot; strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.</td>
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<tr>
<td><strong>Task</strong> If applicable, PPS has implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.</td>
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<td><strong>Task 2.</strong> Assess and Stratify population into risk categories.</td>
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<td><strong>Task 6.</strong> Conduct training on high risk populations, Stanford Model for chronic diseases and linkages to health homes.</td>
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NYS Confidentiality – High
Samaritan Medical Center (PPS ID:45)

### Project Requirements

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#### Milestone #1
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.

Task
Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.

Task
1. Develop/Select Evidence-based strategies for the management and control of diabetes for all participating providers.

Task
2. Develop training materials and conduct staff training for disease management

Task
3. Develop and implement protocols for disease management.

Task
4. Implement Evidence-based strategies for the management and control of diabetes for all participating providers.

#### Milestone #2
Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.

Task
PPS has engaged at least 80% of their PCPs in this activity.

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### Samaritan Medical Center (PPS ID: 45)

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<tbody>
<tr>
<td>1. Evaluate organizational infrastructure and resources required to achieve metrics associated with project 3.c.i</td>
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<td>2. Utilize FDRHPO Communications Committee to support communication needs</td>
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<td>3. Utilize Medical Management Committee to support the engagement of PPS providers in achieving DSRIP transformation.</td>
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<td>4. Indentify PCP's and gain commitment to achieve metrics associated with 3.c.i</td>
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<td>5. Implement and Utilize practitioner communications engagement plan to: inform, improve, sustain two-way communications.</td>
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<td>6. Leverage technological infrastructure to overcome geographical distances between participating providers and to facilitate collaboration</td>
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<td>7. Generate lists of total PCP's in PPS and engage at-least 80% to participate in project.</td>
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**Milestone #3**

Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.

- **Task**
  - Clinically Interoperable System is in place for all participating providers.
- **Task**
  - Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.
- **Task**
  - Care coordination processes are established and implemented.
  - 1. Form care coordination teams that include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers.
- **Task**
  - All participating providers will have a Clinically Interoperable
## Project Requirements (Milestone/Task Name)

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<th>System in place</th>
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<td>Task 4. Validate care coordination processes are in place.</td>
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**Milestone #4**

- Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.

**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**

- 1. Develop improvement processes and plans that address top health disparities and improve workflow
- 2. Assess and stratify population into risk categories.
- 3. Assess and stratify data collection population based on (Race, Ethnicity, and Language) (REAL).
- 4. Establish linkages to health homes for targeted patient populations

**Task**

- 5. Implement Stanford model through partnerships with community-based organizations (CBOs).
- 6. Conduct training on high risk populations, Stanford Model for chronic diseases and linkages to health homes.

**Milestone #5**

- Ensure coordination with the Medicaid Managed Care organizations serving the target population.

**Task**

- PPS has agreement in place with MCO related to coordination

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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID:45)

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

Samaritan Medical Center (PPS ID:45)

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/SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0
Task EHR meets connectivity to RHIO/SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0
Task EHR meets connectivity to RHIO/SHIN-NY requirements. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0

Task 1. EHR meets Meaningful Use Stage 2 CMS requirements (NOTE: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).

Task 2. PPS has achieved NCQA 2014 level 3 PCMH standards and/or APCM.

Task 3. EHR meets connectivity to RHIO/SHIN-NY requirements.

Prescribed Milestones Current File Uploads

<table>
<thead>
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<th>Milestone Name</th>
<th>User ID</th>
<th>File Name</th>
<th>Description</th>
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Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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</thead>
</table>
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings. |
Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices. |
Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management. |
Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk populations. |

NYS Confidentiality – High
## Prescribed Milestones Narrative Text

<table>
<thead>
<tr>
<th>Milestone Name</th>
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</thead>
<tbody>
<tr>
<td>neighborhoods.</td>
<td></td>
</tr>
<tr>
<td>Ensure coordination with the Medicaid Managed Care organizations serving the target population.</td>
<td></td>
</tr>
<tr>
<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
<td></td>
</tr>
<tr>
<td>Meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.</td>
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New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

☑️ IPQR Module 3.c.i.5 - PPS Defined Milestones

Instructions:

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

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

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PPS Defined Milestones Narrative Text

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<tr>
<th>Milestone Name</th>
<th>Narrative Text</th>
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No Records Found
IPQR Module 3.c.i.6 - IA Monitoring

Instructions:

...
Project 3.c.ii – Implementation of evidence-based strategies to address chronic disease - primary and secondary prevention projects (adults only)

☐ IPQR Module 3.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.

“The NCI PPS intends to implement the National Diabetes Prevention Program (NDPP) by leveraging existing partnerships with community-based organizations and by utilizing Electronic Health Records (EHRs) to identify and track pre-diabetic patients and individuals at risk of developing diabetes. Successful project implementation will therefore be contingent upon our partners and upon EHR functionality.

1.) Risk: Risks to implementation presented by our partners include their capacity to offer the class to the high number of regional residents that require intervention, their ability to offer the class at satellite locations (to overcome existing transportation challenges), and the financial sustainability of each program.

Mitigation: NCI is committed to the sustained delivery of the NDPP and will therefore mitigate the outlined risks by using DSRIP funds to offset the cost of expanding the programs and delivering them at the scope required to achieve measurable health improvement.

2.) Risk: The region is characterized by a wide variety of EHR platforms, each with unique functionalities and challenges. One major EHR-based risk to implementation is the flexibility of a particular platform to add functionality allowing providers to seamlessly identify and refer high-risk and pre-diabetic patients to existing community-based prevention programming.

Mitigation: Our PPS has decided to mitigate that risk by conducting a comprehensive assessment of EHR functionality and developing a systematic plan to provide technical assistance to practices requiring added functionality to ensure that the target patient population is sufficiently identified, referred to services and tracked.

3.) Risk: Regional healthcare is currently provided in separate silos with limited ability to share records or care plans. Patients with chronic, complex conditions often have multiple and contradictory care plans with little to no communication between providers and settings. There are no agreed upon protocols for care transitions and little care management across the continuum. Due to the rural geography and transience of many high-risk patients once they leave the “teaching/engaging” moment at the hospital, the Health Home care managers are unable to find them to engage them in outpatient services and active participation in their care plans that would prevent future hospitalizations and ED use. In addition, there is a PC workforce shortage that requires a focused cross-system effort to increase capacity in order that we may serve those with chronic disease burdens. Because CBOs have little to no interaction with inpatient settings or PCPs, there is often a gap in leveraging community support services such as the NDPP. Patients need facilitated, smooth transitions and communication across all settings.

Mitigation: Implementation of a regional care transition project (2biv), regional delivery system integration (2ai) and a strategy to improve PCMH status (2aii).”
Instructions:

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

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Total Commitment</th>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<tr>
<td></td>
<td></td>
<td>DY1,Q1</td>
<td>DY1,Q2</td>
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<tr>
<td>Primary Care Physicians</td>
<td>47</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Non-PCP Practitioners</td>
<td>91</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Clinics</td>
<td>6</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Health Home / Care Management</td>
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<td>0</td>
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<tr>
<td>Behavioral Health</td>
<td>19</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Based Organizations</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All Other</td>
<td>24</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Committed Providers</td>
<td>197</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent Committed Providers(%)</td>
<td>0.00</td>
<td>0.00</td>
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### Samaritan Medical Center (PPS ID: 45)

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<th>Total Commitment</th>
<th>Year, Quarter (DY3,Q3 – DY5,Q4)</th>
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<tr>
<td></td>
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<td>DY3,Q3</td>
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<tr>
<td>Substance Abuse</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Pharmacies</td>
<td>2</td>
<td>0</td>
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<tr>
<td>Community Based Organizations</td>
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<td>0</td>
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<tr>
<td>All Other</td>
<td>24</td>
<td>0</td>
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<tr>
<td><strong>Total Committed Providers</strong></td>
<td><strong>197</strong></td>
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<td><strong>Percent Committed Providers (%)</strong></td>
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**Narrative Text:**

- NYS Confidentiality – High
### IPQR Module 3.c.ii.3 - Patient Engagement Speed

**Instructions:**

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

<table>
<thead>
<tr>
<th>Year,Quarter (DY1,Q1 – DY3,Q2)</th>
<th>DY1,Q1</th>
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<tbody>
<tr>
<td>Patients Engaged</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>20</td>
<td>40</td>
<td>60</td>
<td>80</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Percent of Expected Engagement</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>50.00</td>
<td>25.00</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
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<td>50.00</td>
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<th>Year,Quarter (DY3,Q3 – DY5,Q4)</th>
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<th>DY3,Q4</th>
<th>DY4,Q1</th>
<th>DY4,Q2</th>
<th>DY4,Q3</th>
<th>DY4,Q4</th>
<th>DY5,Q1</th>
<th>DY5,Q2</th>
<th>DY5,Q3</th>
<th>DY5,Q4</th>
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</thead>
<tbody>
<tr>
<td>Patients Engaged</td>
<td>60</td>
<td>80</td>
<td>20</td>
<td>40</td>
<td>60</td>
<td>80</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percent of Expected Engagement</td>
<td>75.00</td>
<td>100.00</td>
<td>25.00</td>
<td>50.00</td>
<td>75.00</td>
<td>100.00</td>
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**Narrative Text:**

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<th>Provider Type</th>
<th>Status</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td><strong>Milestone #1</strong> Implement Center for Disease Control (CDC)-recognized National Diabetes Prevention Programs (NDPP) and/or create partnerships with community sites to refer patients to CDC-recognized programs.</td>
<td>Project</td>
<td>N/A</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> PPS has implemented CDC-recognized National Diabetes Prevention Programs (NDPP) and/or create linkages with community program delivery sites to refer patients to CDC - recognized programs in the community such as the National Diabetes Prevention Program (NDPP), Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Education (DSME).</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td></td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> 1. Identify CBO’s in PPS’s geographical area that offer evidence-based programs and assess service capacity.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td></td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 2. Establish linkages with CBO’s in the PPS’s geographical targeted population areas</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td></td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 3. Develop engagement plan that outlines numbers of CBO’s required, service requirements and alignment of CBO’s specific roles and responsibilities in achieving DSRIP deliverables pertaining to chronic disease</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td></td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong> 4. Partner with and contract CBO’s in diabetes prevention programs.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2016</td>
<td></td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 5. Incorporate communication of DPP into NCI DSRIP communications plan to: inform, improve, sustain two-way communications.</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>06/30/2016</td>
<td></td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
</tr>
<tr>
<td><strong>Task</strong> 6. Utilize existing CBO expertise to prevent overgrowth or duplication of existing services</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2016</td>
<td></td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> 7. Provide prevention information to CBO’s about DPP, recognition process and training opportunities (include in NCI DSRIP Communication Plan)</td>
<td>Project</td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>12/31/2016</td>
<td></td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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## Samaritan Medical Center (PPS ID: 45)

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<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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</thead>
<tbody>
<tr>
<td><strong>Task 8. Identify appropriate public sector agencies at the state and local level in the NCI service area</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task 9. Develop an action plan for coordinating supporting agency activities within the PPS for discussion, review, and adoption by the Agencies and Municipal Authorities in advocating early identification of pre-diabetes.</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td><strong>Milestone #2 Use EHRs or other technical platforms to track all patients engaged in this project.</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task 1. Identify targeted patient population through data collection</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
</tr>
<tr>
<td><strong>Task 2. Integrate clinical decision support functions based on evidence-based guidelines into EHR (i.e., order sets, alerts).</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task 3. Track / Monitor actively engaged patients utilizing designated tracking systems</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task 4. Report actively engaged patients against milestone completion</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task 5. Routinely measure outcomes through quality assessment</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Milestone #3 Identify high-risk patients (including those at risk for onset of diabetes or with pre-diabetes) and establish referral process to institutional or community NDPP delivery sites.</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> PPS has identified patients and referred them to either institutional or community NDPP delivery sites.</td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td><strong>Task 1. Implement and utilize NCI DSRIP communications plan to: inform, improve, sustain two-way communications. Where appropriate and accepted utilize electronic referrals processes.</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>09/30/2016</td>
<td>09/30/2016</td>
<td>DY2 Q2</td>
</tr>
<tr>
<td><strong>Task 2. Showcase our regions DPP programs, while building support of these programs through introductions of key personnel and sharing of critical</strong></td>
<td>Project</td>
<td></td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<td>Start Date</td>
<td>End Date</td>
<td>Quarter</td>
<td>DSRIP Reporting Year and Quarter</td>
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<tr>
<td>Task</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Enhance and leverage current systems to include identification of pre-diabetes and referral to recognized Diabetes Prevention Program</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for NDPP.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
<td>06/30/2016</td>
<td>DY2 Q1</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Support local media campaigns aimed at identified priority populations to increase awareness of pre-diabetes and encourage participation in NDPP.</td>
<td>Project</td>
<td>In Progress</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
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<td>Ensure collaboration with PCPs and program sites to monitor progress and provide ongoing recommendations.</td>
<td>Project N/A</td>
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<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
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<td>Task 1. Strategic use of health communication and marketing tools to raise awareness chronic diseases:</td>
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New York State Department Of Health  
Delivery System Reform Incentive Payment Project  
DSRIP Implementation Plan Project  

Samaritan Medical Center (PPS ID:45)

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<tr>
<td>Task</td>
<td>PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.</td>
<td>Project</td>
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<tr>
<td>Task</td>
<td>1. Implement a care coordination model to increase clinical-community linkage with local health departments, home care agencies and other community organization to promote self management support</td>
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<td>Task</td>
<td>2. Geographically determine current Health Homes: range of care, limitations, and ability to provide coordination of care (existing care relationships, care coordination experience, health IT systems and networks).</td>
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<td>Task</td>
<td>3. Integrate Community Health Workers into the system of care.</td>
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<td>Task</td>
<td>4. Partner with local health departments and identify and engage Community Health Worker networks.</td>
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<td>Task</td>
<td>5. Promote DSRIP focusing on improving care for populations with chronic disease to MCOs.</td>
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<td>Task</td>
<td>7. Utilize VBP plans to strategically involve the MCO's in our plans and strategies around DPP programs.</td>
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<tr>
<td>Milestone #1</td>
<td>Implement Center for Disease Control (CDC)-recognized National Diabetes Prevention Programs (NDPP) and/or create partnerships with community sites to refer patients to CDC-recognized programs.</td>
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<tr>
<td>Task</td>
<td>PPS has implemented CDC-recognized National Diabetes Prevention Programs (NDPP) and/or create linkages with</td>
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--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
Community program delivery sites to refer patients to CDC-recognized programs in the community such as the National Diabetes Prevention Program (NDPP), Chronic Disease Self-Management Program (CDSMP) and Diabetes Self-Management Education (DSME).  
**Task**  
1. Identify CBO’s in PPS’s geographical area that offer evidence-based programs and assess service capacity.  
2. Establish linkages with CBO’s in the PPS’s geographical targeted population areas  
3. Develop engagement plan that outlines numbers of CBO’s required, service requirements and alignment of CBO’s specific roles and responsibilities in achieving DSRIP deliverables pertaining to chronic disease  
4. Partner with and contract CBO’s in diabetes prevention programs.  
5. Incorporate communication of DPP into NCI DSRIP communications plan to: inform, improve, sustain two-way communications.  
6. Utilize existing CBO expertise to prevent overgrowth or duplication of existing services  
7. Provide prevention information to CBO’s about DPP, recognition process and training opportunities (include in NCI DSRIP Communication Plan)  
8. Identify appropriate public sector agencies at the state and local level in the NCI service area  
9. Develop an action plan for coordinating supporting agency activities within the PPS for discussion, review, and adoption by the Agencies and Municipal Authorities in advocating early identification of pre-diabetes.  
**Milestone #2**  
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.
## New York State Department Of Health
### Delivery System Reform Incentive Payment Project
### DSRIP Implementation Plan Project

**Samaritan Medical Center (PPS ID: 45)**

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<tr>
<td>Task 1. Identify targeted patient population through data collection</td>
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<td>Task 2. Integrate clinical decision support functions based on evidence-based guidelines into EHR (i.e., order sets, alerts).</td>
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<td>Task 3. Track / Monitor actively engaged patients utilizing designated tracking systems</td>
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<td>Task 4. Report actively engaged patients against milestone completion</td>
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<td>Task 5. Routinely measure outcomes through quality assessment</td>
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### Milestone #3
Identify high-risk patients (including those at risk for onset of diabetes or with pre-diabetes) and establish referral process to institutional or community NDPP delivery sites.

**Task**
PPS has identified patients and referred them to either institutional or community NDPP delivery sites.

- **Task 1.** Implement and utilize NCI DSRIP communications plan to: inform, improve, sustain two-way communications. Where appropriate and accepted utilize electronic referrals processes.

### Task 2.
Showcase our regions DPP programs, while building support of these programs through introductions of key personnel and sharing of critical information needed to embrace these programs

### Task 3.
Enhance and leverage current systems to include identification of pre-diabetes and referral to recognized Diabetes Prevention Program

### Task 4.
Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for NDPP.

### Task 5.
Support local media campaigns aimed at identified priority populations to increase awareness of pre-diabetes and encourage participation in NDPP.

### Milestone #4
Ensure collaboration with PCPs and program sites to monitor progress and provide ongoing recommendations.

NYS Confidentiality – High
## Samaritan Medical Center (PPS ID:45)

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**DSRIP Implementation Plan Project**

**Samaritan Medical Center (PPS ID:45)**

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**Task**  
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**Task**  
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**Task**  
3. Educate employers and wellness professionals utilizing CBO's body of knowledge of wellness lifestyles

**Task**  
4. Utilize Social Media to promote healthy lifestyle programs

**Task**  
5. Partner with care coordinators on development of lifestyle modification programs as to assist in the involvement of all key stakeholders and patient advocates

**Task**  
6. Educate patients on medication usage and control

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**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**  
1. Implement a care coordination model to increase clinical-community linkage with local health departments, home care agencies and other community organization to promote self management support

**Task**  
2. Geographically determine current Health Homes: range of care, limitations, and ability to provide coordination of care (existing care relationships, care coordination experience, ...
# New York State Department Of Health
## Delivery System Reform Incentive Payment Project
### DSRIP Implementation Plan Project

**Samaritan Medical Center (PPS ID:45)**

### Project Requirements

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<thead>
<tr>
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<th>DY1,Q2</th>
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NYS Confidentiality – High
### Samaritan Medical Center (PPS ID: 45)

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<td>Task 5. Incorporate communication of DPP into NCI DSRIP communications plan to: inform, improve, sustain two-way communications.</td>
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<td>Task 6. Utilize existing CBO expertise to prevent overgrowth or duplication of existing services</td>
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<td>Task 7. Provide prevention information to CBO's about DPP, recognition process and training opportunities (include in NCI DSRIP Communication Plan)</td>
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<td>Task 8. Identify appropriate public sector agencies at the state and local level in the NCI service area</td>
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<td>Task 9. Develop an action plan for coordinating supporting agency activities within the PPS for discussion, review, and adoption by the Agencies and Municipal Authorities in advocating early identification of pre-diabetes.</td>
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<td>Task 1. Identify targeted patient population through data collection</td>
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<td>Task 2. Integrate clinical decision support functions based on evidence-based guidelines into EHR (i.e., order sets, alerts).</td>
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<td>Task 3. Track / Monitor actively engaged patients utilizing designated tracking systems</td>
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<td>Task 4. Report actively engaged patients against milestone completion</td>
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<td>Task 5. Routinely measure outcomes through quality assessment</td>
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<td>Identify high-risk patients (including those at risk for onset of</td>
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Project Requirements
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--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---
diabetes or with pre-diabetes and establish referral process to institutional or community NDPP delivery sites.

Task
PPS has identified patients and referred them to either institutional or community NDPP delivery sites.

Task
1. Implement and utilize NCI DSRIP communications plan to: inform, improve, sustain two-way communications. Where appropriate and accepted utilize electronic referrals processes.

Task
2. Showcase our regions DPP programs, while building support of these programs through introductions of key personnel and sharing of critical information needed to embrace these programs

Task
3. Enhance and leverage current systems to include identification of pre-diabetes and referral to recognized Diabetes Prevention Program

Task
4. Plan and execute strategic data-driven actions through a network of partners and local organizations to build support for NDPP.

Task
5. Support local media campaigns aimed at identified priority populations to increase awareness of pre-diabetes and encourage participation in NDPP.

Milestone #4
Ensure collaboration with PCPs and program sites to monitor progress and provide ongoing recommendations.

Task
PPS has trained staff to facilitate referrals to NDPP delivery sites and provide supports and follow-up to patients. PPS periodically conducts audits to ensure that referrals are made and patients are being treated with evidence-based strategies in the community to assist them with primary and secondary prevention strategies to reduce risk factors for diabetes and other co-occurring chronic diseases. (adult only).

Task
PPS has trained staff to facilitate referrals to NDPP delivery sites and provide supports and follow-up to patients. PPS periodically conducts audits to ensure that referrals are made and patients are being treated with evidence-based strategies in the community to assist them with primary and secondary prevention strategies to reduce risk factors for diabetes and other co-occurring chronic diseases. (adult only).

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<td>other co-occurring chronic diseases. (adult only).</td>
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<td>Task 1. Develop population registries / metrics that demonstrate stratification by risk, conditions, or other criteria important to chronic disease management</td>
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<td>Task 2. Collaborative &amp; on-going consultations via PCP’s method of choice (phone, note, secure email, conversation).</td>
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<td>Task 3. Maintain positive and collaborative working relationships with network practitioners and providers</td>
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<td>Task 4. Demonstrate a capacity to use health IT to link services that facilitate communication among healthcare team members: the patient, and family caregivers; and provide feedback to practices, as appropriate.</td>
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<td>Milestone #5 Establish lifestyle modification programs including diet, tobacco use, and exercise and medication compliance.</td>
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<td>Task Lifestyle modification programs that focus on lifestyle modification are created and implemented as part of care plan. Program recommendations are consistent with community resources.</td>
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<td>Task 1. Strategic use of health communication and marketing tools to raise awareness chronic diseases:</td>
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<td>Task 2. Enhance public awareness of lifestyle change programs and how to enroll in these lifestyle programs</td>
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<td>Task 5. Partner with care coordinators on development of lifestyle modification programs as to assist in the involvement of all key stakeholders and patient advocates</td>
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<td>Task 6. Educate patients on medication usage and control</td>
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<td>Ensure coordination with Medicaid Managed Care organizations and Health Homes for eligible/involved patients.</td>
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## Prescribed Milestones Current File Uploads

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## Prescribed Milestones Narrative Text

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<td>Use EHRs or other technical platforms to track all patients engaged in this project.</td>
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<tr>
<td>Identify high-risk patients (including those at risk for onset of diabetes or with pre-diabetes) and establish referral process to institutional or community NDPP delivery sites.</td>
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<tr>
<td>Ensure collaboration with PCPs and program sites to monitor progress and provide ongoing recommendations.</td>
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<tr>
<td>Establish lifestyle modification programs including diet, tobacco use, and exercise and medication compliance.</td>
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<tr>
<td>Ensure coordination with Medicaid Managed Care organizations and Health Homes for eligible/involved patients.</td>
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</tbody>
</table>
New York State Department Of Health
Delivery System Reform Incentive Payment Project
DSRIP Implementation Plan Project

Samaritan Medical Center (PPS ID:45)

✅ IPQR Module 3.c.ii.5 - PPS Defined Milestones

Instructions:

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

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

<table>
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PPS Defined Milestones Narrative Text

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<th>Milestone Name</th>
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</table>
IPQR Module 3.c.ii.6 - IA Monitoring

Instructions:
### Project 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure across Systems

#### IPQR Module 4.a.iii.1 - PPS Defined Milestones

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones. For Domain 4 projects, these milestones must align with content submitted in the PPS Application.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milestone</strong> 1. Participate in Mental, Emotional and Behavioral (MEB) health promotion and MEB disorder prevention partnerships</td>
<td>In Progress</td>
<td>Participate in Mental, Emotional and Behavioral (MEB) health promotion and MEB disorder prevention partnerships</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong> a. Collaborate with key MEB influencers (local health departments, local government, community stakeholders) to clarify roles in MEB infrastructure</td>
<td>In Progress</td>
<td>Collaborate with key MEB influencers (local health departments, local government, community stakeholders) to clarify roles in MEB infrastructure</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> b. Leverage 2013 and 2014 community needs assessments to identify specific MEB issues to be addressed</td>
<td>In Progress</td>
<td>Leverage 2013 and 2014 community needs assessments to identify specific MEB issues to be addressed</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> c. Identify key stakeholders to serve on an interdisciplinary team to address identified MEB issues</td>
<td>In Progress</td>
<td>Identify key stakeholders to serve on an interdisciplinary team to address identified MEB issues</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> d. Develop interdisciplinary team charter (that includes rationale, assets, challenges, goals, objectives, baseline data, interventions to be implemented)</td>
<td>In Progress</td>
<td>Develop interdisciplinary team charter (that includes rationale, assets, challenges, goals, objectives, baseline data, interventions to be implemented)</td>
<td>04/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td><strong>Task</strong> e. Implement interventions, track progress, make improvements as needed</td>
<td>In Progress</td>
<td>Implement interventions, track progress, make improvements as needed</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Milestone</strong> 2. Collaborative care in primary care settings</td>
<td>In Progress</td>
<td>Collaborative care in primary care settings</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td><strong>Task</strong></td>
<td>In Progress</td>
<td>Implement IMPACT Model (Collaborative Care) at Primary Care Sites.</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Milestone/Task Name</td>
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<tr>
<td><strong>a. Implement IMPACT Model (Collaborative Care) at Primary Care Sites.</strong></td>
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<td><strong>Task</strong></td>
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<tr>
<td>i. In collaboration with NCI Workforce, Care Coordination and Medical Management</td>
<td>In Progress</td>
<td>In collaboration with NCI Workforce, Care Coordination and Medical Management Committees, explore and identify evidence-based IMPACT (Collaborative Care) Model training programs</td>
<td>07/01/2015</td>
<td>09/30/2015</td>
<td>09/30/2015</td>
<td>DY1 Q2</td>
</tr>
<tr>
<td>Committees, explore and identify evidence-based IMPACT (Collaborative Care) Model</td>
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<tr>
<td>ii. Secure IMPACT Model training program</td>
<td>In Progress</td>
<td>Secure IMPACT Model training program</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
</tr>
<tr>
<td>iii. Identify appropriate project workforce for IMPACT model training</td>
<td>In Progress</td>
<td>Identify appropriate project workforce for IMPACT model training</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>iv. Document commitment from project workforce for IMPACT Model training</td>
<td>In Progress</td>
<td>Document commitment from project workforce for IMPACT Model training</td>
<td>07/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>v. Develop and implement evidence-based strategies for the IMPACT model at</td>
<td>In Progress</td>
<td>Develop and implement evidence-based strategies for the IMPACT model at identified primary care sites</td>
<td>07/01/2015</td>
<td>09/30/2017</td>
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<td>identified primary care sites</td>
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<tr>
<td>vi. Provide quarterly report narrative demonstrating successful implementation of</td>
<td>In Progress</td>
<td>Provide quarterly report narrative demonstrating successful implementation of project requirements (IMPACT Model implemented at PCP sites)</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
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<tr>
<td>project requirements (IMPACT Model implemented at PCP sites)</td>
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<td><strong>Task</strong></td>
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<tr>
<td>b. Utilize IMPACT Model collaborative care standards, including developing</td>
<td>In Progress</td>
<td>Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
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<td>DY2 Q4</td>
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<td>coordinated evidence-based care standards and policies and procedures for care</td>
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<td>engagement.</td>
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<tr>
<td>i. In collaboration with NCI Workforce, Care Coordination and Medical Management</td>
<td>In Progress</td>
<td>In collaboration with NCI Workforce, Care Coordination and Medical Management Committees, ensure identified and appropriate workforce are IMPACT Model trained and able to demonstrate practical, evidence-based approaches to recognizing and treating depression in a variety of clinical settings, especially with clinically challenging cases (i.e. persistent depressions and comorbid or psychiatric conditions)</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
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<td>DY2 Q4</td>
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<tr>
<td>Committees, ensure identified and appropriate workforce are IMPACT Model trained</td>
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<td>and able to demonstrate practical, evidence-based approaches to recognizing and</td>
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<td>treating depression in a variety of clinical settings, especially with clinically</td>
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<td>challenging cases (i.e. persistent depressions and comorbid or psychiatric</td>
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<td>persistent depressions and comorbid or psychiatric conditions)</td>
<td>In Progress</td>
<td>Provide documentation of evidence-based practice guidelines and protocols to include medication management and care engagement processes to facilitate collaboration between primary care physician and care manager</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task i. Provide documentation of evidence-based practice guidelines and protocols to include medication management and care engagement processes to facilitate collaboration between primary care physician and care manager</td>
<td>In Progress</td>
<td>Provide documentation of evidence-based practice guidelines and protocols to include medication management and care engagement processes to facilitate collaboration between primary care physician and care manager</td>
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<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task ii. Provide documentation of evidence-based practice guidelines and protocols to include medication management and care engagement processes to facilitate collaboration between primary care physician and care manager</td>
<td>In Progress</td>
<td>Provide documentation of evidence-based practice guidelines to include a process for consulting with Psychiatrist</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task iii. Provide documentation of evidence-based practice guidelines to include a process for consulting with Psychiatrist</td>
<td>In Progress</td>
<td>Employ a trained Depression Care Manager meeting requirements of the IMPACT model.</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task iv. Provide documentation of evidence-based practice guidelines to include a process for consulting with Psychiatrist</td>
<td>In Progress</td>
<td>Designate a Psychiatrist meeting requirements of the IMPACT Model.</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task v. Provide documentation of evidence-based practice guidelines to include a process for consulting with Psychiatrist</td>
<td>In Progress</td>
<td>Identify consulting psychiatrists via telemedicine who will collaborate with PCMH providers and depression care managers to provide evidence-based standards of care including medication management, care engagement processes, and the integration of depression treatment into Primary Care to improve physical and social functioning</td>
<td>07/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
<td>DY2 Q3</td>
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NYS Confidentiality – High
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<tbody>
<tr>
<td>Depression treatment into Primary Care to improve physical and social functioning</td>
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<tr>
<td>Task ii. Work in partnership with NCI IT, Medical Management and PCMH teams to ensure technological infrastructure is in place for private, secure telemedical consults with a identified psychiatrists</td>
<td>In Progress</td>
<td>Work in partnership with NCI IT, Medical Management and PCMH teams to ensure technological infrastructure is in place for private, secure telemedical consults with a identified psychiatrists</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task iii. Provide documentation related to registration of IMPACT participants and designated Psychiatrist</td>
<td>In Progress</td>
<td>Provide documentation related to registration of IMPACT participants and designated Psychiatrist</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
</tr>
<tr>
<td>Task iv. Provide documentation of policies and procedures related to follow up with care of patients</td>
<td>In Progress</td>
<td>Provide documentation of policies and procedures related to follow up with care of patients</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Task v. Provide EHR documentation identifying Psychiatrists for eligible patients</td>
<td>In Progress</td>
<td>Provide EHR documentation identifying Psychiatrists for eligible patients</td>
<td>07/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Task e. Measure outcomes as required in the IMPACT Model.</td>
<td>In Progress</td>
<td>Measure outcomes as required in the IMPACT Model.</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
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<tr>
<td>Task i. Provide roster of screened patients</td>
<td>In Progress</td>
<td>Provide roster of screened patients</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
</tr>
<tr>
<td>Task ii. Develop protocols to ensure care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter using tools such as the PHQ2/9</td>
<td>In Progress</td>
<td>Develop protocols to ensure care managers measure depressive symptoms at the start of a patient's treatment and regularly thereafter using tools such as the PHQ2/9</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
</tr>
<tr>
<td>Task f. Provide &quot;stepped care&quot; as required by the IMPACT Model.</td>
<td>In Progress</td>
<td>Provide &quot;stepped care&quot; as required by the IMPACT Model.</td>
<td>07/01/2015</td>
<td>03/31/2018</td>
<td>03/31/2018</td>
<td>DY3 Q4</td>
</tr>
<tr>
<td>Task i. Provide documentation of evidence-based practice guidelines for stepped care including implementation plan</td>
<td>In Progress</td>
<td>Provide documentation of evidence-based practice guidelines for stepped care including implementation plan</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
<td>06/30/2017</td>
<td>DY3 Q1</td>
</tr>
<tr>
<td>Task ii. Documentation of treatment adjusted based on clinical outcomes and according to evidence-based algorithms to include things such as medication dosages, a change to a different medication, addition of psychotherapy, a combination of medication and</td>
<td>In Progress</td>
<td>Documentation of treatment adjusted based on clinical outcomes and according to evidence-based algorithms to include things such as medication dosages, a change to a different medication, addition of psychotherapy, a combination of medication and</td>
<td>07/01/2015</td>
<td>06/30/2017</td>
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<td>DY3 Q1</td>
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</table>
### Milestone/Task Name | Status | Description | Start Date | End Date | Quarter End Date | DSRIP Reporting Year and Quarter
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| evidence-based algorithms to include things such as medication dosages, a change to a different medication, addition of psychotherapy, a combination of medication and psychotherapy, or other treatment as suggested by the team psychiatrist | In Progress | Psychotherapy, or other treatment as suggested by the team psychiatrist | 07/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2
| Task | iii. Working in collaboration with NCI clinical teams, develop targets which aim for a certain percentage (i.e. 50%) in the reduction of symptoms within a certain time period (i.e. 10-12 weeks) | In Progress | Working in collaboration with NCI clinical teams, develop targets which aim for a certain percentage (i.e. 50%) in the reduction of symptoms within a certain time period (i.e. 10-12 weeks) | 07/01/2015 | 09/30/2017 | 09/30/2017 | DY3 Q2
| Task | g. Use EHRs or other technical platforms to track all patients engaged in this project. | In Progress | Use EHRs or other technical platforms to track all patients engaged in this project. | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4
| Task | i. In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records | In Progress | In collaboration with NCI's IT team and participating providers, track engaged patients in this project using EHR documentation demonstrating integration of medical and behavioral health record within individual patient records | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4
| Task | ii. Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports. | In Progress | Working in collaboration with NCI's IT, data and clinical team, gather data and track target patients by using EHR reports. | 07/01/2015 | 03/31/2017 | 03/31/2017 | DY2 Q4
| Milestone | 3. Cultural and linguistic training on MEB health promotion, prevention and treatment | In Progress | Cultural and linguistic training on MEB health promotion, prevention and treatment | 04/01/2015 | 12/31/2016 | 12/31/2016 | DY2 Q3
| Task | a. Conduct assessment to understand community and provider characteristics, including an understanding of MEB promotion | In Progress | Conduct assessment to understand community and provider characteristics, including an understanding of MEB promotion | 04/01/2015 | 03/31/2016 | 03/31/2016 | DY1 Q4
| Task | b. Conduct an assessment of cultural competency among regional providers | In Progress | Conduct an assessment of cultural competency among regional providers | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2
| Task | c. Train providers to deliver evidence-based care that is integrated with MEB promotion and disorder prevention | In Progress | Train providers to deliver evidence-based care that is integrated with MEB promotion and disorder prevention | 04/01/2015 | 09/30/2016 | 09/30/2016 | DY2 Q2

NYS Confidentiality – High
### Milestone/Task Name  | Status  | Description                                                                                                                                                                                                 | Start Date | End Date  | Quarter End Date | DSRIP Reporting Year and Quarter
---|---|---|---|---|---|---
**Disorder prevention**  |  |  |  |  |  |  
**Task**

**d. Identify and deliver curricula for children and youth to enhance their social skills, emotional competence, and conflict resolution and coping skills**  
In Progress  
Identify and deliver curricula for children and youth to enhance their social skills, emotional competence, and conflict resolution and coping skills  
04/01/2015  
12/31/2016  
12/31/2016  
DY2 Q3

**Task**

**e. Identify and deliver curricula to members of partnership on MEB health promotion, prevention and treatment using the Institute of Medicine Intervention Spectrum framework**  
In Progress  
Identify and deliver curricula to members of partnership on MEB health promotion, prevention and treatment using the Institute of Medicine Intervention Spectrum framework  
04/01/2015  
12/31/2016  
12/31/2016  
DY2 Q3

**Milestone**

**4. Share data and information on MEB health promotion and MEB disorder prevention and treatment**  
In Progress  
Share data and information on MEB health promotion and MEB disorder prevention and treatment  
04/01/2015  
09/30/2016  
09/30/2016  
DY2 Q2

**Task**

**a. Collaborate with key influencers to identify data sources that can be used to share information on MEB issues within the community**  
In Progress  
Collaborate with key influencers to identify data sources that can be used to share information on MEB issues within the community  
04/01/2015  
09/30/2016  
09/30/2016  
DY2 Q2

**Task**

**b. Include MEB data and information sharing in NCI DSRIP Communication Plan**  
In Progress  
Include MEB data and information sharing in NCI DSRIP Communication Plan  
04/01/2015  
09/30/2016  
09/30/2016  
DY2 Q2

**Task**

**c. At least quarterly share MEB data and information using DSRIP Communication Channels**  
In Progress  
At least quarterly share MEB data and information using DSRIP Communication Channels  
04/01/2015  
09/30/2016  
09/30/2016  
DY2 Q2

### PPS Defined Milestones Current File Uploads

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<tbody>
<tr>
<td>1. Participate in Mental, Emotional and Behavioral (MEB) health promotion and MEB disorder prevention partnerships</td>
<td></td>
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<tr>
<td>2. Collaborative care in primary care settings</td>
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<tr>
<td>3. Cultural and linguistic training on MEB health promotion, prevention and treatment</td>
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<tr>
<td>4. Share data and information on MEB health promotion and MEB disorder prevention and treatment</td>
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</table>
IPQR Module 4.a.iii.2 - IA Monitoring

Instructions:
Project 4.b.ii – Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer)

**IPQR Module 4.b.ii.1 - PPS Defined Milestones**

Instructions:

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones. For Domain 4 projects, these milestones must align with content submitted in the PPS Application.

<table>
<thead>
<tr>
<th>Milestone/Task Name</th>
<th>Status</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Quarter End Date</th>
<th>DSRIP Reporting Year and Quarter</th>
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<tbody>
<tr>
<td>Milestone 1. Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services</td>
<td>In Progress</td>
<td>Establish or enhance reimbursement and incentive models to increase delivery of high-quality chronic disease prevention and management services</td>
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<td>03/31/2017</td>
<td>03/31/2017</td>
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<tr>
<td>Task a. Coordinate with Medical Management Committee to develop PPS-wide approach to incentivize clinicians to refer to preventive services</td>
<td>In Progress</td>
<td>Coordinate with Medical Management Committee to develop PPS-wide approach to incentivize clinicians to refer to preventive services</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
<td>03/31/2017</td>
<td>DY2 Q4</td>
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<tr>
<td>Task b. Work with Medical Management Committee to identify opportunities to incorporate referral to preventive services in VBP planning</td>
<td>In Progress</td>
<td>Work with Medical Management Committee to identify opportunities to incorporate referral to preventive services in VBP planning</td>
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<td>Task c. Work with VBP workgroup to incorporate referral to preventive services in VBP planning</td>
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<td>Work with VBP workgroup to incorporate referral to preventive services in VBP planning</td>
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<td>Milestone 2. Offer recommended clinical preventive services</td>
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<td>Task a. Incorporate focused cancer screening policies/protocols into PPS primary care partners workflow during PCMH implementations, where appropriate, including standing orders that address the ordering,</td>
<td>In Progress</td>
<td>Incorporate focused cancer screening policies/protocols into PPS primary care partners workflow during PCMH implementations, where appropriate, including standing orders that address the ordering, review, and follow-up or evidence-based cancer screening tests</td>
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<td>review, and follow-up or evidence-based cancer screening tests</td>
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<tr>
<td>b. Increase provider/care team knowledge of screening protocols and clinical practice guidelines by incorporating into NCI DSRIP Communication Plan</td>
<td>In Progress</td>
<td>Increase provider/care team knowledge of screening protocols and clinical practice guidelines by incorporating into NCI DSRIP Communication Plan</td>
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<td>c. Increase provider/care team knowledge of screening protocols and clinical practice guidelines by incorporation into PPS Primary Care workforce training plan</td>
<td>In Progress</td>
<td>Increase provider/care team knowledge of screening protocols and clinical practice guidelines by incorporation into PPS Primary Care workforce training plan</td>
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<tr>
<td>d. Increase provider/care team knowledge of screening protocols and clinical practice guidelines by implementing communication and workforce training plan</td>
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<td>Increase provider/care team knowledge of screening protocols and clinical practice guidelines by implementing communication and workforce training plan</td>
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<tr>
<td>Milestone 3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and community partners</td>
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<td>Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and community partners</td>
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<tr>
<td>a. Conduct meta-analysis of existing Community Service Plans to identify PPS-wide strategies to address preventive screening rates</td>
<td>In Progress</td>
<td>Conduct meta-analysis of existing Community Service Plans to identify PPS-wide strategies to address preventive screening rates</td>
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<tr>
<td>b. Revise plans to include Prevention Agenda goals regarding preventive services</td>
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<td>Revise plans to include Prevention Agenda goals regarding preventive services</td>
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<td>4. Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management</td>
<td>In Progress</td>
<td>Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management</td>
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<td>In Progress</td>
<td>Conduct an assessment of the current practices and clinics to determine the needed</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>1. Conduct an assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are fully utilizing EHRs to provide coordinated care across the PPS.</td>
<td>In Progress</td>
<td>Perform a gap analysis and a plan with budget to address the identified needs</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>2. Perform a gap analysis and a plan with budget to address the identified needs</td>
<td>In Progress</td>
<td>Begin implementations with prioritization based on attributed Medicaid population and provider engagement.</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
<td>03/31/2016</td>
<td>DY1 Q4</td>
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<tr>
<td>3. During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, &amp; issues are communicated and a plan is in place to address them.</td>
<td>In Progress</td>
<td>During the implementation phase and all phases that follow, prepare a report to the governance committee to ensure that all risks, &amp; issues are communicated and a plan is in place to address them.</td>
<td>04/01/2015</td>
<td>06/30/2016</td>
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<td>DY2 Q1</td>
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<tr>
<td>4. Perform a post-go-live gap analysis and a plan with budget to address the identified needs</td>
<td>In Progress</td>
<td>Perform a post-go-live gap analysis and a plan with budget to address the identified needs</td>
<td>04/01/2015</td>
<td>03/31/2017</td>
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<tr>
<td>5. Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</td>
<td>In Progress</td>
<td>Facilitate the practice's connection with the HealtheConnections RHIO and the regional PHM platform to ensure they have access to all information the patient has consented to in order to provide efficient, effective and high-quality care.</td>
<td>04/01/2015</td>
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<td>03/31/2018</td>
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<tr>
<td>6. Perform a pre-MU and PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to attest for MU and apply for NCQA PCMH by DSRIP DY3.</td>
<td>In Progress</td>
<td>Perform a pre-MU and PCMH assessment of the current practices and clinics to determine the needed infrastructure, training and implementation required to ensure all providers are utilizing the EHR and operating as a PCMH in order to attest for MU and apply for NCQA PCMH by DSRIP DY3.</td>
<td>04/01/2015</td>
<td>03/31/2016</td>
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<tr>
<td>7. Begin MU attestations &amp; PCMH recognitions</td>
<td>In Progress</td>
<td>Begin MU attestations &amp; PCMH recognitions with prioritization based on attributed Medicaid population and provider engagement.</td>
<td>04/01/2015</td>
<td>12/31/2016</td>
<td>12/31/2016</td>
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</table>
### Milestone/Task Name

with prioritization based on attributed Medicaid population and provider engagement.

<table>
<thead>
<tr>
<th>Task 9. Establish PPS-wide approaches for alerting providers/care team about patients due for screenings and about follow-up on test results</th>
<th>In Progress</th>
<th>Establish PPS-wide approaches for alerting providers/care team about patients due for screenings and about follow-up on test results</th>
<th>04/01/2015</th>
<th>03/31/2018</th>
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<tbody>
<tr>
<td>Task 10. Establish PPS-wide approaches for reminding patients they are due for screening or in need of follow-up</td>
<td>In Progress</td>
<td>Establish PPS-wide approaches for reminding patients they are due for screening or in need of follow-up</td>
<td>04/01/2015</td>
<td>03/31/2018</td>
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<table>
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<tr>
<th>Milestone 5. Adopt medical home or team-based care models</th>
<th>In Progress</th>
<th>Adopt medical home or team-based care models</th>
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<th>03/31/2018</th>
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<tbody>
<tr>
<td>Task a. Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
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<td>Assess all participating PCPs to determine their preparedness for NCQA 2014 Level 3 PCMH.</td>
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<tr>
<td>Task b. Perform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
<td>In Progress</td>
<td>Perform a gap analysis on the results to determine the scope of work/needed assistance for each PCP.</td>
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<td>Task c. Create a project plan/timeline for each PCP</td>
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<td>Create a project plan/timeline for each PCP</td>
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NYS Confidentiality – High
## Samaritan Medical Center (PPS ID:45)

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<tr>
<td>d. Implement the PCMH processes, procedures, protocols and written policies.</td>
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<td>Implement the PCMH processes, procedures, protocols and written policies.</td>
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<tr>
<td>e. Complete the NCQA Level 3 PCMH submissions</td>
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<td>f. All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates</td>
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<td>All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards. Receive the NCQA Level 3 PCMH Recognition Certificates</td>
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<td>6. Create linkages with and connect patients to community prevention resources</td>
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<td>Create linkages with and connect patients to community prevention resources</td>
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<td>c. Deploy CHWs to &quot;hot spot&quot; areas to identify underserved residents and establish linkages to preventive care</td>
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underserved residents and establish linkages to preventive care

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### Milestone

7. Provide feedback to clinicians around clinical benchmarks and incentivize quality improvement efforts

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### Task

a. Establish PPS-wide approach to monitor and share screening performance results with all care team members as outlined in organizational section practitioner engagement plan

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### Milestone

8. Reduce or eliminate out-of-pocket costs for clinical and community preventive services

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### Task

a. Identify and coordinate with insurance navigators to connect patients to coverage for clinical preventive services

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### Task

b. Provide at no cost and/or link to no/low cost community based prevention services that target regional high rates of chronic disease as identified in the CNA - specifically Tobacco Cessation, Colorectal cancer screening and DPP

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<td>2. Offer recommended clinical preventive services</td>
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<td>3. Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and community partners</td>
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<td>4. Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality. Send reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management</td>
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<td>5. Adopt medical home or team-based care models</td>
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<td>6. Create linkages with and connect patients to community prevention resources</td>
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IPQR Module 4.b.ii.2 - IA Monitoring

Instructions:

Milestone 1: IA suggests more detailed steps toward establishing the incentive models be developed following coordination with the Medical Management Committee.
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 'Samaritan Medical Center', that all information provided on this Quarterly report is true and accurate to the best of my knowledge.

Primary Lead PPS Provider: SAMARITAN MEDICAL CENTER
Secondary Lead PPS Provider:
Lead Representative: Thomas H Carman
Submission Date: 09/24/2015 12:16 PM

Comments:
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