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

Domain 1 DSRIP Project Requirements Milestones and Metrics:

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Domain 3 DSRIP Project Plan Applications

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

Index Score = 56

Project Requirement		Metric/Deliverable*	Data Source(s)
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.	PPS includes continuum of providers in IDS, including Medical, behavioral health, post-acute, long-term care, and community-based providers.	Provider network list; Periodic reports demonstrating changes to network list; Contractual agreements.
2	Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	PPS produces a list of participating HHs and ACOs.	Updated network provider lists; written agreements.
		Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Periodic progress reports on implementation that demonstrate a path to evolve HH or ACO into IDS.
		Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees.

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

Index Score = 56

Project Requirement		Metric/Deliverable*	Data Source(s)
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.	Clinically Interoperable System is in place for all participating providers.	HIE Systems report, if applicable; Process work flows; Documentation of process and workflow including responsible resources at each stage of the workflow; Other sources demonstrating implementation of the system
		PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	Process flow diagrams demonstrating IDS processes
		PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.	Contract; Report; Periodic reporting of discharge plans uploaded into EHR; Other sources demonstrating implementation of the system
		PPS trains staff on IDS protocols and processes.	Written training materials; list of training dates along with number of staff trained.
	Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions

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

Index Score = 56

Project Requirement		Metric/Deliverable*	Data Source(s)
4	sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
5	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification; DURSA certification
		PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	Certification documentation
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.	PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Sample patient registries; EHR completeness reports (necessary data fields sufficently accurate to conduct population health management)
		Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Status reporting of recruitment of PCPs, particularly in high-need areas; Demonstration of improved access via CAHPS measurement;

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

Index Score = 56

Project Requirement		Metric/Deliverable*	Data Source(s)
7	Achieve 2014 Level 3 PCMH primary care certification, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	All practices meet NCQA Level 3 PCMH and/or APCM standards.	List of participating NCQA-certified physicians/practitioners; Certification documentation
		EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Meaningful Use certification; DURSA certification
8	Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Medicaid Managed Care contract(s) are in place that include value-based payments.	Documentation of executed Medicaid Managed Care contracts; Report demonstrating percentage of total provider Medicaid reimbursement using value-based payments
9	Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Meeting minutes; agendas; attendee lists; meeting materials; process of reporting meeting outcomes/recommendations to stakeholders and PPS leadership
	Re-enforce the transition towards value-based	PPS has a plan to evolve provider compensation model to incentive-based compensation	Compensation model; implementation plan; consultant recommendations

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

Index Score = 56

Project Requirement		Metric/Deliverable*	Data Source(s)
10	payment reform by aligning provider compensation to patient outcomes.	Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Contract; Report; Payment Voucher; Other sources demonstrating implementation of the compensation and performance management system
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.	Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	Documentation of partnerships with community-based organizations; Evidence community health worker hiring; Co-location agreements/job descriptions; Report on how many patients are engaged with community health worker

**Define the specific tasks and timelines necessary to achieve these project requirement metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.ii**
Project Title	**Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the New York State Health Innovation Plan (SHIP))**

Index Score = 37

	Project Requirement	Metric/Deliverable*	Data Source(s)
1	Ensure that all primary care providers within 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.	All practices meet NCQA Level 3 PCMH and/or APCM standards.	List of participating NCQA-certified physicians/practitioners; Certification documentation
2	Identify a physician champion with knowledge of PCMH implementation for each primary care practice included in the project.	PPS has identified physician champion with experience implementing PCMHs.	Role description; CV (explicating NCQA certification, PCMH content expert, population health experience); Contract; Certifications
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.	Care coordinators are identified for each primary care site.	List of names of care coordinators at each primary care site
		Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities.	Role descriptions; Written training materials
		Clinical Interoperability System in place for all participating providers and document usage by the identified care coordinators.	HIE Systems report, if applicable; Process work flows; Documentation of process and workflow including responsible resources at each stage of the workflow; Other sources demonstrating implementation of the system

Project Domain	**System Transformation Projects (Domain 2)**
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Index Score = 37

Project Requirement		Metric/Deliverable*	Data Source(s)
4	Ensure all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
		PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
5	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification; DURSA certification
		PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	Certification documentation
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.	PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Sample patient registries; EHR completeness reports (necessary data fields sufficently accurate to conduct population health management)

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.ii**
Project Title	**Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the New York State Health Innovation Plan (SHIP))**

Index Score = 37

Project Requirement		Metric/Deliverable*	Data Source(s)
7	Ensure that all staff are trained on PCMH or Advanced Primary Care models, including evidence-based preventive and chronic disease management.	Practice has adopted preventative and chronic care protocols aligned with national guidelines.	Policies and procedures related to standardized treatment protocols for chronic disease management; agreements with PPS organizations to implement consistent standardized treatment protocols.
		Project staff are trained on policies and procedures specific to evidence-based preventative and chronic disease management.	Documentation of training program; Written training materials; List of training dates along with number of staff trained
8	Implement preventive care screening protocols including behavioral health screenings (PHQ-9, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.	Preventive care screenings implemented amoung participating PCPs, including behavioral health screenings (PHQ-9, SBIRT).	OQPS Reporting Requirements; claims reporting; number and types of screenings implemented; numbers of patients screened; numbers of providers trained on screening protocals
		Protocals and processes for referral to appropriate services are in place.	HIE Systems report, if applicable; Process work flows; Documentation of process and workflow including responsible resources at each stage of the workflow; Other sources demonstrating implementation of the system

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.ii**
Project Title	**Increase Certification of Primary Care Practitioners with PCMH Certification and/or Advanced Primary Care Models (as developed under the New York State Health Innovation Plan (SHIP))**

Index Score = 37

Project Requirement		Metric/Deliverable*	Data Source(s)
9	Implement open access scheduling in all primary care practices.	PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.	Scheduling Standards Documentation; Report showing third next available appointment (Institute for Healthcare Improvement measures); Response times reporting; Materials communicating practice hours; Vendor System Documentation, if applicable; Other Sources demonstrating implementation
		PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.	Scheduling Standards Documentation; Report showing third next available appointment (Institute for Healthcare Improvement measures); Response times reporting; Materials communicating practice hours; Vendor System Documentation, if applicable; Other Sources demonstrating implementation
		PPS monitors and decreases no-show rate by at least 15%.	Baseline no-show rate with periodic reports demonstrating 15% no-show rate reduction

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.iii**
Project Title	**Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services**

Index Score = 46

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH PCPs in care coordination within the program.	A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with defintion of roles of PCMH PCPs and HHs	Complete strategic plan; Reports on progress in implementation that demonstrate a path to successful implementation within the timeframe committed to in the application
2	Ensure all participating primary care providers in project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year 3.	All practices meet NCQA Level 3 PCMH and APCM standards	List of participating NCQA-certified physicians/practitioners; Certification documentation
	Ensure that all participating providers are actively sharing EHR systems with local health	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.iii**
Project Title	**Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services**

Index Score = 46

Project Requirement		Metric/Deliverable*	Data Source(s)
3	information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
4	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification; DURSA certification
		PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	Certification documentation
5	Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Sample patient registries; EHR completeness reports(necessary data fields are populated in order to track project implementation and progress)

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.iii**
Project Title	**Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services**

Index Score = 46

Project Requirement		Metric/Deliverable*	Data Source(s)
6	Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Procedures to engage at-risk patients with care management plan instituted.	Documentation of process and workflow including responsible resources at each stage; Written training materials; List of training dates, including number of staff trained; Sample care management plans; Sample patient outreach; Number of patients engaged with care management plan
7	Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Each identified PCP establish partnerships with the local Health Home for care management services.	Information-sharing policies and procedures; Number of patients provided care management services
8	Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	PPS has established partnerships to medical, behavioral health, and social services.	Policies and procedures with list of active partner providers and agencies; written agreements with partner providers and agencies; processes and notifications; clinical teams processes and group decision-making
		PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.	EHR vendor documentation; protocols for use of EHR vendor documentation for referrals

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.iii**
Project Title	**Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services**

Index Score = 46

Project Requirement		Metric/Deliverable*	Data Source(s)
9	Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.	Documentation of evidence-based practice guidelines; Process and workflow including responsible resources at each stage; Written training materials; List of training dates; Chronic condition protocols and training materials
		Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees
		PPS has included social services agencies in development of risk reduction and care practice guidelines.	Meeting minutes; List of attendees; agreements with social services agencies
		Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.	Educational materials; evaluation of materials for cultural competence

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline in the project plan application.*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.iv**
Project Title	**Create a medical village using existing hospital infrastructure**

Index Score = 54

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Convert outdated or unneeded hospital capacity into an outpatient services center, stand-alone emergency department/urgent care center or other healthcare-related purpose.	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	Complete strategic plan; Reports on progress in implementation that demonstrate a path to successful implementation within the timeframe committed to in the application
		Project must reflect community involvement in the development and the specific activities that will be undertaken during the project term.	Meeting minutes; List of attendees and organizations represented
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.	PPS has bed reduction timeline and implementation plan in place with achievable targeted reduction in "staffed" beds.	Certificate of Need (CON) for bed reduction; Bed reduction timeline; Baseline bed capacity and periodic progress reports documenting bed reduction.

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.iv**
Project Title	**Create a medical village using existing hospital infrastructure**

Index Score = 54

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
3	Ensure that all project participants 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.	All practices meet NCQA Level 3 PCMH and/or APCM standards.	List of participating NCQA-certified physicians/practitioners; Certification documentation
4	Ensure that all Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
5	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)
6	Ensure that EHR systems used in Medical Villages meet Meaningful Use and PCMH Level 3 standards.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification; DURSA certification

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.iv**
Project Title	**Create a medical village using existing hospital infrastructure**

Index Score = 54

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
7	Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) must be supported by the comprehensive community needs assessment.	Strategy developed for migration of any services to different setting or location (clinic, hospitals, etc).	Migration plan; Justification for migration as evidenced by CNA; Policies and Procedures; Version Log

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.v**
Project Title	**Create a medical village/alternative housing using existing nursing home infrastructure**

Index Score = 42

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Transform outdated (underperforming) nursing home capacity into a stand-alone emergency department/urgent care center or other healthcare-related purpose.	Execute project to reduce outdates nursing home capacity into a stand-alone, "medical village"	Implementation plan to provide improved access; Reports on progress in implementation that demonstrate a path to successful implementation.
2	Provide a clear statement of how the infrastructure transformation program will promote better service and outcomes (service volume, occupancy statistics, etc.) for the community based upon the community needs assessment including evaluation of specific planning needs for any Naturally Occurring Retirement Community (NORC) occurring within the PPS.	PPS has completed evaluation of community needs, including planning needs for NORCs, and has developed goals to provide improved access to needed services.	Implementation Plan; Reports on progress in implementation that demonstrate a path to successful implementation.

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.v**
Project Title	**Create a medical village/alternative housing using existing nursing home infrastructure**

Index Score = 42

Project Requirement		Metric/Deliverable*	Data Source(s)
3	Provide a clear description of how this re-configured facility will fit into a broader integrated delivery system that is committed to high quality care and willing/able to participate in payment reform.	PPS has developed a clear strategic plan, which includes, at a minimum: - Definition of services to be provided in medical village and justification based on CNA - Plan for transition of nursing home infrastructrue to other needed services - 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	Reports on progress in implementation that demonstrate a path to successful implementation, in the timeframe committed to, in the application, which shall include: - project report on status and challenges - status of progress towards achievement of core components based on project metrics in Work Plan
4	Providing a clear documentation that demonstrates housing plans are consistent with the Olmstead Decision and any other federal requirements.	Medical village services and housing are compliant with Olmstead Decision and federal requirements.	Documentation of housing access to or integrated supports for elders and persons with disabilities

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.v**
Project Title	**Create a medical village/alternative housing using existing nursing home infrastructure**

Index Score = 42

Project Requirement		Metric/Deliverable*	Data Source(s)
5	Identify specific community-based services that will be developed in lieu of these beds based upon the community need.	PPS increases capacity of community-based services as identified in Community Needs Assessment.	Documentation of new community services available; Baseline outpatient volume with periodic reports demonstrating increase in outpatient visits
6	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)
7	Ensure that all project participants 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.	All practices meet NCQA Level 3 PCMH and/or APCM standards.	List of participating NCQA-certified physicians/practitioners; Certification documentation
8	Ensure that all medical villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.a.v**
Project Title	**Create a medical village/alternative housing using existing nursing home infrastructure**

Index Score = 42

Project Requirement		Metric/Deliverable*	Data Source(s)
9	Ensure that EHR systems used in Medical Villages meet Meaningful Use and PCMH Level 3 standards.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification; DURSA certification

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.i**
Project Title	**Ambulatory ICUs**

Index Score = 36

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Ensure Ambulatory ICU is staffed by or has access to a network of providers including medical, behavioral health, nutritional, rehabilitation and other necessary provider specialties that is sufficient to meet the needs of the target population.	PPS has recruited intra- or inter-network specialty resources; ensuring expertise in medical; behavioral; nutritional; rehabilitation; and other necessary specialties.	List of participating NCQA-certified physicians/practitioners; Certification documentation
		PPS has established a standard clinical protocol for Ambulatory ICU services.	Standard Clinical Protocol
2	Ensure Ambulatory ICU is integrated with all relevant Health Homes in the community.	PPS has defined physicians/practitioners that will participate.	List of physicians/practitioners
3	Use EHRs and other technical platforms to track all patients engaged in the project, including collecting community data and Health Home referrals.	Eligible patients have been identified.	Documentation of Process and System Requirements; documentation of population health logic methodology
4	Establish care managers co-located at each Ambulatory ICU site.	PPS has co-located health home care managers and social support services.	Documented evidence of health home and social support care managers operating in Ambulatory ICU sites; Attestation
	Ensure that all project participants are actively sharing EHR systems with local health	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.i**
Project Title	**Ambulatory ICUs**

Index Score = 36

	Project Requirement	Metric/Deliverable*	Data Source(s)
5	information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging.	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
6	Ensure that EHR systems used by participating providers meet Meaningful Use and PCMH Level 3 standards.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification; DURSA certification
		PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	Certification documentation
7	Implementation of a secure patient portal that supports patient communication and engagement as well as provides assistance for self-management.	Secure patient portal supporting patient communication and engagement.	Documented portal functionality; Screen Shots of patient communication system; staff training documentation
8	Establish a multi-disciplinary, team-based care review and planning process to ensure that all Ambulatory ICU patients benefit from the input of multiple providers.	Policies and procedures are in place for team based care planning.	Documentation of process/procedures and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.i**
Project Title	**Ambulatory ICUs**

Index Score = 36

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
9	Deploy a provider notification/secure messaging system to alert care managers and Health Homes of important developments in patient care and utilization.	EMR System with Real Time Notification System is in use.	Documented Process; Screen Shots of Real Time Notification System; Training Documentation
10	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.ii**
Project Title	**ED care triage for at-risk populations**

Index Score = 36

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Ensure appropriate location of the co-located primary care services in the ED. All relocated PCMH practices will meet NCQA 2014 Level 3 PCMH standards within 2 years after relocation.	Relocated PCMH practices located in the ED achieve NCQA Level 3 PCMH standards and/or APCM 2 years after relocation.	List of participating NCQA-certified physicians/practitioners; Certification documentation
2	Ensure that new practices will meet NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. At start up, the practice must have open access scheduling extended hours, and have EHR capability that is interoperable with the ED.	All practices meet NCQA Level 3 PCMH and/or APCM standards.	List of participating NCQA-certified physicians/practitioners; Certification documentation
		All new practices meet NCQA PCMH 1A scheduling standards.	Scheduling Standards Documentation; report showing third next available appointment (Institute for Healthcare Improvement measures); Response times reporting; Materials communicating practice hours; Vendor System Documentation, if applicable
		All new practices meet NCQA PCMH 1B scheduling standards.	Scheduling Standards Documentation; report showing third next available appointment (Institute for Healthcare Improvement measures); Response times reporting; Materials communicating practice hours; Vendor System Documentation

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.ii**
Project Title	**ED care triage for at-risk populations**

Index Score = 36

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
3	Develop care management protocols for triage and referral to ensure compliance with EMTALA standards.	Care management protocols and procedures for triage and triage and referral are developed, in concert with practitioners in the PCMH, are in place and consistent with EMTALA standards.	Care Management protocols and procedures; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained
4	Ensure EHR utilization including supporting secure notifications/messaging, as well as sharing medicial records between the participating in the local health providers via Meaningful Use standards.	EHR suppports secure notifications/messaging and the sharing of medical records.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions.
		EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Meaningful Use certification; DURSA certification.
5	Establish protocols and training for care coordinators to assist patients in understanding use of the health system, promote self-management and knowledge on appropriate care.	Care Coordinator and ED policies and procedures are in place to manage overall population health and perform as an integrated clinical team.	Policies and procedures; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.ii**
Project Title	**ED care triage for at-risk populations**

Index Score = 36

Project Requirement		Metric/Deliverable*	Data Source(s)
6	Implement a comprehensive payment and billing strategy. (The PCMH may only bill usual primary care billing codes and not emergency billing codes.)	PCMH bills only primary care, not emergency, billing codes.	Periodic self-audit of procedure codes billed; payment agreements requiring non-emergency
7	Develop protocols for connectivity to the assigned health plan PCP and real-time notification to the Health Home care manager as applicable.	EMR System with Real Time Notification System is in use.	Documented Process; Screen Shots of Real Time Notification System; Training Documentation
8	Utilize culturally competent community based organizations to raise community awareness of alternatives to the emergency room.	Community awareness program to raise awareness of alternatives to the emergency room is established with community-based organizations.	Program Budget; Documented Process; Written attestation or evidence of agreement with Community Organizations; Written training materials
		PCMH 1A Access During Office Hours scheduling to meet NCQA standards established across all PPS primary care sites.	Scheduling Standards Documentation; Report showing third next available appointment (Institute for Healthcare Improvement measures); Response times reporting; Materials communicating practice hours; Vendor System Documentation, if applicable; Other Sources demonstrating implementation

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.ii**
Project Title	**ED care triage for at-risk populations**

Index Score = 36

Project Requirement		Metric/Deliverable*	Data Source(s)
9	Implement open access scheduling in all primary care practices.	PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.	Scheduling Standards Documentation; Report showing third next available appointment (Institute for Healthcare Improvement measures); Response times reporting; Materials communicating practice hours; Vendor System Documentation, if applicable; Other Sources demonstrating implementation
		PPS monitors and decreases no-show rate by at least 15%.	Baseline no-show rate with periodic reports demonstrating 15% no-show rate reduction
10	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.iii**
Project Title	**ED care triage for at-risk populations**

Index Score = 43

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Establish ED care triage program for at-risk populations	Stand up program based on project requirements	Status of implementation through Implementation Plan milestones; Quarterly Reports
2	Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	All practices meet NCQA Level 3 PCMH and/or APCM standards.	List of participating NCQA-certified physicians/practitioners; Certification documentation
		EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Meaningful Use certification; DURSA certification.
		Encounter Notification Service (ENS) is installed in all PCP and EDs	Contract Review of PPS; Screen shots of Installation in PCP and EDs; Report; Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.iii**
Project Title	**ED care triage for at-risk populations**

Index Score = 43

Project Requirement		Metric/Deliverable*	Data Source(s)
3	For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.	Protocol documentation, Detailed Steps and Process Flows within the ER; Other Sources demonstrating implementation of the system; list of non-emergent encounters eligible for triage

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.iii**
Project Title	**ED care triage for at-risk populations**

Index Score = 43

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
4	Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	Protocol documentation; ED encounter report includes billings algorithm categorization including 1. Non-Emergent 2. Emergent/Primary Care Treatable (CAT Scans or Lab Test) 3. Emergent ED Care Needed/Avoidable (asthma flare-ups, diabetes, heart failure, etc...) 4. Emergent ED Care Needed - Not Preventable/Avoidable
5	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.iv**
Project Title	**Care transitions intervention model to reduce 30 day readmissions for chronic health conditions**

Index Score = 43

Project Requirement		Metric/Deliverable*	Data Source(s)
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.	Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	List of participating NCQA-certified physicians/practitioners; Certification documentation
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.	A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Payment Agreements or MOUs with Managed Care Plans
		Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	Documentation of methodology and strategies including identification of responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations; Written attestation or evidence of coordination of care transition strategies with Health Homes and the supportive housing site
		PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.	Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.iv**
Project Title	**Care transitions intervention model to reduce 30 day readmissions for chronic health conditions**

Index Score = 43

Project Requirement		Metric/Deliverable*	Data Source(s)
3	Ensure required social services participate in the project.	Required network social services, including medically tailored home food services, are provided in care transitions.	Support Services Lists; Documentation of process and workflow including responsible resources at each stage of the workflow; Written attestation or evidence of agreement; Periodic self-audit reports and recommendations
4	Transition of care protocols will include early notification of planned discharges and the ability of the transition case manager to visit the patient in the hospital to develop the transition of care services.	Policies and procedures are in place for early notification of planned discharges.	Documentation of early notification of planned discharge process and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained
		PPS has program in place that allows case managers access to visit patients in the hospital and provide care transition services and advisement.	Contract; Vendor System Documentation, if applicable; Other Sources demonstrating case manager access to the system
5	Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	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.	Documentation of care record transition process and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained; Periodic self-audit reports and recommendations

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.iv**
Project Title	**Care transitions intervention model to reduce 30 day readmissions for chronic health conditions**

Index Score = 43

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
6	Ensure that a 30-day transition of care period is established.	Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Policies and Procedures
7	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.v**
Project Title	**Care transitions intervention for skilled nursing facility (SNF) residents**

Index Score = 41

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Partner with associated SNFs to develop a standardized protocol to assist with resolution of the identified issues.	Partnership agreements are in place between hospitals and SNFs and include agreements to coordinate post-admission care.	Written agreements; Network provider list
		SNFs and hospitals have developed care transition policies and procedures, including coordination of thorough and accurate post-admission medical records; ongoing meetings are held to evaluate and improve process.	Policies and Procedures; Meeting minutes
2	Engage with the Medicaid Managed Care Organizations and Managed Long Term Care or FIDA Plans associated with their identified population to develop transition of care protocols, ensure covered services including DME will be readily available, and that there is	PPS has engaged with Medicaid Managed Care and Managed Long Term Care or FIDA plans to develop coordination of care and care transition strategies; PPS has developed agreements and protocols to provide post-admission transition of care services.	Written agreements; Policies and Procedures; Documentation of process and workflow including responsible resources at each stage
		Covered services, including Durable Medical Equipment, are available for the identified population.	Contract; Report; Other sources demonstrating service availability

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.v**
Project Title	**Care transitions intervention for skilled nursing facility (SNF) residents**

Index Score = 41

Project Requirement		Metric/Deliverable*	Data Source(s)
	a payment strategy for the transition of care services.	A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care and Managed Long Term Care or FIDA Plans.	Documentation of methodology and strategies including identification of responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations; Written attestation or evidence of payment agreements
3	Develop transition of care protocols will include timely notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. Ensure that all relevant protocols allow patients in end-of-life situations to transition home with all appropriate services.	Policies and procedures are in place for early notification of planned discharges.	Documentation of early notification of planned discharge process and workflow including responsible resources at each stage
		PPS has program in place that allows SNF staff access to visit patients in the hospital and participate in care transition planning.	Written agreements; Policies and Procedures
4	Establish protocols for standardized care record transitions to the SNF staff and medical personnel.	Clinical Interoperability System is in place for all participating providers.	HIE Systems report, if applicable; Process work flows; Documentation of process and workflow including responsible resources at each stage of the workflow; Other sources demonstrating implementation of the system

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.v**
Project Title	**Care transitions intervention for skilled nursing facility (SNF) residents**

Index Score = 41

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
5	Ensure all participating hospitals and SNFs have shared EHR system capability and HIE/RHIO/SHIN-NY access for electronic transition of medical records by the end of DSRIP Year 3.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions.
6	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.vi**
Project Title	**Transitional supportive housing services**

Index Score = 47

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Partner with community housing providers and home care service organizations to develop transitional supportive housing for high-risk patients.	Service agreements, contracts, MOUs between PPS and community housing providers and/or home care service organizations.	MOUS; Service agreements; letters of commitment, other documentation
2	Develop protocols to identify chronically ill super-utilizers who qualify for this service. Once identified, this targeted population will be monitored using a priority listing for access to transitional supportive housing.	Policies and procedures are in place for super-utilizer identification specific to priority housing access.	List of participating NCQA-certified physicians/practitioners; Certification documentation; priority listing for tranistioned patients indicating successful transition to permanent housing
3	Establish MOUs and other service agreements between participating hospitals and community housing providers to allow the supportive housing and home care services staff to meet with patients in the hospital and coordinate the transition.	MOUs between supportive housing/home care services and hospitals are established and allow for in-hospital transition planning.	MOUs; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained
4	Establish coordination of care strategies with Medicaid Managed Care Organizations to ensure needed services at discharge are covered and in place at the transitional supportive housing site.	Coordination of care strategies focused on discharge services are in place, in concert with Medicaid Managed Care Organizations, for the supportive housing site.	MCO Contracts; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.vi**
Project Title	**Transitional supportive housing services**

Index Score = 47

Project Requirement		Metric/Deliverable*	Data Source(s)
5	Develop transition of care protocols to ensure all chronically ill super-utilizers receive appropriate health care and community support including medical, behavioral health, post-acute care, long-term care and public health services.	Policies and procedures are in place for transition of care specifically to address medical, behavioral health and social needs of patients.	Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained
6	Ensure medical records and post-discharge care plans are transmitted in a timely manner to the patient's primary care provider and frequently used specialists.	EHR meets Meaningful Use stage 1/2 CMS requirements; Documentation exhibiting timely transfer of patient medical records to patient's PCP and specialists, as appropriate	Meaningful Use certification; DURSA certification.
7	Establish procedures to connect the patient to their Health Home (if a HH member) care manager in the development of the transitional housing plan or provides a "warm" referral for assessment and enrollment into a Health Home (with assignment of a care manager).	Policies and procedures are in place among hospitals and health homes for engagement/assignment of a care manager.	Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained; contract between Hospital and Health Homes; other sources demonstrating implementation of related engagement/assignment systems

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.vi**
Project Title	**Transitional supportive housing services**

Index Score = 47

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
8	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

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

Index Score = 41

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	INTERACT principles implemented at each participating SNF.	Quarterly reports demonstrating successful implementation of project requirements
		Nursing home to hospital transfers reduced.	Baseline nursing home to hospital transfer volume with periodic reports demonstrating decrease in transfers
		INTERACT 3.0 Toolkit used at each SNF.	Evidence of INTERACT 3.0 toolkit use and rationale
2	Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Facility champion identified for each SNF.	Role description; CV (explicating experience with INTERACT principles); Contract; Certifications
3	Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Documentation of care pathway and clinical tool(s) methodology
		PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Documented strategic plan for monitoring of critically ill patients and hospital avoidance; Implementation plan; Written training materials; List of training dates along with number of staff trained
4	Educate all staff on care pathways and INTERACT principles.	Training program for all SNF staff established encompassing care pathways and INTERACT principles.	List of training dates along with number of staff trained; Written training materials

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

Index Score = 41

Project Requirement		Metric/Deliverable*	Data Source(s)
5	Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Evidence of tool(s)/Toolkit materials
6	Create coaching program to facilitate and support implementation.	INTERACT coaching program established at each SNF.	List of training dates along with number of staff trained; Written training materials
7	Educate patient and family/caretakers, to facilitate participation in planning of care.	Patients and families educated and involved in planning of care using INTERACT principles.	Patient/family education methodology; Patient/family involvement methodology
8	Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Meaningful Use certification; DURSA certification.
		EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions.

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

Index Score = 41

Project Requirement		Metric/Deliverable*	Data Source(s)
9	Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Quality committee membership list with indication of organization represented and staff category, if applicable
		Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes
		PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans
		Service and quality outcome measures are reported to all stakeholders.	Website URLs with published reports; Newsletters; Documentation demonstrating distribution of quality outcomes
10	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.viii**
Project Title	**Hospital-Home Care Collaboration Solutions**

Index Score = 45

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services	Quarterly reports demonstrating successful implementation of project requirements; List of Rapid Response Team staff; Procedures and protocols
2	Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventative medicine - chronic disease management	List of training dates along with number of staff trained; Written training materials
		Evidence-based guidelines for chronic-condition management implemented.	Evidence-based practice guidelines; Implementation plan
3	Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Documentation of care pathway and clinical tool(s) methodology
		PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Documented strategic plan for monitoring of critically ill patients and hospital avoidance; Implementation plan; Written training materials; List of training dates along with number of staff trained

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.viii**
Project Title	**Hospital-Home Care Collaboration Solutions**

Index Score = 45

Project Requirement		Metric/Deliverable*	Data Source(s)
4	Educate all staff on care pathways and INTERACT-like principles.	Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	List of training dates along with number of staff trained; Written training materials
5	Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Evidence of tool(s)/Toolkit materials
6	Create coaching program to facilitate and support implementation.	INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	List of training dates along with number of staff trained; Written training materials
7	Educate patient and family/caretakers, to facilitate participation in planning of care.	Patients and families educated and involved in planning of care using INTERACT-like principles.	Patient/family education methodology; Patient/family involvement methodology
8	Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	All relevant services (physical, behavioral, pharmalogical) integrated into care and medication management model.	Care coordination methodology; Medication management methodology
9	Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.	Implementation plan; Evidence of use of telemedicine services

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.viii**
Project Title	**Hospital-Home Care Collaboration Solutions**

Index Score = 45

Project Requirement		Metric/Deliverable*	Data Source(s)
10	Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.	HIE Systems report, if applicable; Process work flows; Documentation of process and workflow including responsible resources at each stage of the workflow; Other sources demonstrating implementation of the system
11	Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Quality committee membership list with indication of organization represented and staff category, if applicable
		Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes
		PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.viii**
Project Title	**Hospital-Home Care Collaboration Solutions**

Index Score = 45

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
		Service and quality outcome measures are reported to all stakeholders.	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes
12	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

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

Index Score = 36

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Establish appropriately sized and staffed observation (OBS) units in close proximity to ED services, unless the services required are better provided in another unit. When the latter occurs, care coordination must still be provided.	Observation units established in proximity to PPS' ED departments.	Opportunity assessment for OBS units; Implementation plan for OBS units; Quarterly reports demonstrating successful implementation of project requirements
		Care coordination is in place for patients routed outside of ED or OBS services.	Care coordination methodology
2	Create clinical and financial model to support the need for the unit.	PPS has clinical and financial model, detailing: - number of beds - staffing requirements - services definition - admission protocols - discharge protocols - inpatient transfer protocols	Baseline clinical and financial model, with periodic updates demonstrating gap to clinical and financial goals
3	Utilize care coordination services to ensure safe discharge either to the community or a step down level of service, such as behavioral health or assisted living/SNF.	Standard 30-day care coordination services for safe discharge to community or step-down level are implemented and specifically fitted to short-stay situations.	Care coordination methodology for safe discharge, with short-stay protocol specifications

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

Index Score = 36

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
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 secure notifications/messaging, by the end of Demonstration Year 3.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Meaningful Use certification; DURSA certification
		EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
5	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.c.i**
Project Title	**To develop a community based health navigation service to assist patients to access healthcare services efficiently**

Index Score = 37

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Create community-based health navigation services, with the goal of assisting patients in accessing healthcare services efficiently.	Community-based health navigation services established.	Quarterly reports demonstrating successful implementation of project requirements
2	Develop a community care resource guide to assist the community resources and ensure compliance with protocols, under direction from a collaborating program oversight group of medical/behavioral health, community nursing, and social support services providers.	Resource guide completed, detailing medical/behavioral/social community resources and care protocols developed by program oversight committee.	Resource guide; List of training dates along with number of staff trained; Written training materials
3	Recruit for community navigators, ideally spearheaded by residents in the targeted area to ensure community familiarity.	Navigators recruited by residents in the targeted area, where possible.	List of community navigators; Contracts; Evidence of resident/community involvement
4	Resource appropriately for the community navigators, evaluating placement and service type.	Navigator placement implemented based upon opportunity assessment.	Strategic plan for navigator placement; List of navigator locations, detailing proximity to community-based organizations and target patients
		Telephonic and web-based health navigator services implemented by type.	Strategic plan for implementation of each navigator service type (in-person, telephonic, web-based)

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.c.i**
Project Title	**To develop a community based health navigation service to assist patients to access healthcare services efficiently**

Index Score = 37

Project Requirement		Metric/Deliverable*	Data Source(s)
5	Provide community navigators with access to non-clinical resources, such as transportation and housing services.	Navigators have partnerships with transportation, housing, and other social services benefitting target population.	Documentation of partnerships with non-clinical resources
6	Establish case loads and discharge processes to ensure efficiency in the system for community navigators who are following patients longitudinally.	Case loads and discharge processes established for health navigators following patients longitudinally.	Case load and discharge process methodology
7	Market the availability of community-based navigation services.	Health navigator personnel and services marketed within designated communities.	Comprehensive marketing plan
8	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.c.ii**
Project Title	**Expand Usage of Telemedicine in Underserved Areas to Provide Access to otherwise Scarce Services**

Index Score = 31

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Implement telemedicine services, aimed at reducing avoidable hospital use by increasing patient access to services not otherwise available and/or increasing specialty expertise of primary care providers and their staff in order to increase availability of scarce specialty services.	Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services that would benefit - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability	Quarterly reports demonstrating successful implementation of project requirements
2	Provide equipment specifications and rationale for equipment choice (including cost of acquisition, maintenance and sustainability of service).	Equipment specifications (meeting certified standards for interoperability and communications) and rationale documented.	Equipment specifications; Equipment rationale

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.c.ii**
Project Title	**Expand Usage of Telemedicine in Underserved Areas to Provide Access to otherwise Scarce Services**

Index Score = 31

Project Requirement		Metric/Deliverable*	Data Source(s)
3	Define service area and participating providers, with clear delineation between telemedicine hub sites versus spoke sites.	Service area, delineated between spoke and hub sites, defined.	Implementation plan with delineated service areas and corresponding providers.
4	Procure service agreements for provision of telemedicine services such as specialty services, participating primary care and nurse triage monitoring.	Service agreements in place for provision of telemedicine services.	Written attestation or evidence of agreement
5	Develop standard service protocols, as well as consent and confidentiality standards meeting all federal and state requirements.	Telemedicine service, consent, and confidentiality protocols developed to meet federal and state requirements for: - patient eligibility - appointment availability - medical record protocols - educational standards - continuing education credits	Service/consent/confidentiality protocols; Documentation of process and workflow including responsible resources at each stage; Written training materials; List of training dates along with number of staff trained
6	Coordinate with Medicaid Managed Care Organizations to develop and ensure service authorization and payment strategies are in place to support sustainability of patient care uses.	Service authorization and payment strategies developed, in concert with Medicaid Managed Care companies.	Written attestation or evidence of agreement

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.c.ii**
Project Title	**Expand Usage of Telemedicine in Underserved Areas to Provide Access to otherwise Scarce Services**

Index Score = 31

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
7	Use EHRs and other technical platforms to track all patients engaged in the project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

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

Index Score = 56

Project Requirements		Metric/Deliverable*	Data Source(s)
1	Partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.	MOUs, contracts, letters of agreement or other partnership documentation; Quarterly reports demonstrating successful implementation of project requirements
2	Establish a PPS-wide training team, comprised of members with training in PAM® and expertise in patient activation and engagement.	Patient Activation Measure® (PAM®) training team established.	Description of the following components: the names and roles of team staff trained in PAM®, by whom they were trained, copy training agenda materials, and team staff roles who will be engaged in patient activation
3	Identify UI, NU, and LU “hot spot” areas (e.g., emergency rooms). Partner with CBOs to perform outreach within the identified “hot spot” areas.	Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	"Hot spot" map delineated by UI, NU, LU types; Evidence of CBO outreach within appropriate "hot spot" areas; Outreach lists for UI, NU, and LU populations
4	Survey the targeted population about healthcare needs in the PPS’ region.	Community engagement forums and other information-gathering mechanisms established and performed.	List of community forums held, detailing locations, agenda, and presenters; Documentation surveys or other information-gathering techniques

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

Index Score = 56

Project Requirements		**Metric/Deliverable***	**Data Source(s)**
5	Train providers located within “hot spots” on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM® trainers".	List of PPS providers trained in PAM®; Training dates; Written training materials

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

Index Score = 56

Project Requirements		Metric/Deliverable*	Data Source(s)
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). • 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. • 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.	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.	Documented procedures and protocols; Information-exchange agreements between PPS and MCO

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

Index Score = 56

Project Requirements		Metric/Deliverable*	Data Source(s)
7	Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM® during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	For each PAM® activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).	Baseline, periodic and annual PAM® cohort reports and presentations
8	Include beneficiaries in development team to promote preventive care.	Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.	List of contributing patient members participating program development and awareness efforts

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

Index Score = 56

	Project Requirements	Metric/Deliverable*	Data Source(s)
9	Measure PAM® 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® survey and designate a PAM® score. ▯ Individual member 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.	Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM® survey implementation - Number of patient:PCP bridges established - Number of patients identified, linked by MCOs to which they are associated	Performance measurement reports and presentations; Annual reports; Member engagement lists, by PAM® cohort

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

Index Score = 56

Project Requirements		Metric/Deliverable*	Data Source(s)
	• 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® 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.	- 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	
10	Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Volume of non-emergent visits, for UI, NU, and LU populations, increased.	Baseline non-emergent volume with periodic reports demonstrating increase in visits (specific to UI, NU, and LU patients)

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

Index Score = 56

Project Requirements		**Metric/Deliverable***	**Data Source(s)**
11	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.	Community navigators identified and contracted.	Periodic list of community navigator credentials (by designated area), detailing navigator names, location, and contact information
		Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	List of training dates along with number of staff trained; Written training materials
12	Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Policies and procedures for customer service complaints and appeals developed.	Documented procedures and protocols
13	Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM®.	List of community navigators formally trained in the PAM®.	Description including the following components: the names and roles of team staff trained in PAM®, by whom they were trained, copy training agenda materials, and team staff roles who will be engaged in patient activation

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

Index Score = 56

Project Requirements		**Metric/Deliverable***	**Data Source(s)**
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.	Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	Evidence of navigator placement by location
15	Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Navigators educated about insurance options and healthcare resources available to populations in this project.	List of navigators trained by PPS; Names of PPS trainers; Training dates; Written training materials
16	Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Timely access for navigator when connecting members to services.	Policies and procedures for intake and/or scheduling staff to receive navigator calls; List of provider intake staff trained by PPS
17	Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Sample patient registries; EHR completeness reports (necessary data fields sufficently accurate to conduct population health management)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.i (Model 1)**
Project Title	**Integration of primary care and behavioral health services**

Index Score = 39

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Co-locate behavioral health services at primary care practice sites. Primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY3.	All practices meet NCQA Level 3 PCMH and/or APCM standards by the end of DY3.	List of provides meeting NCQA Level 3 PCMH; Certification documentation
		Behavioral health services are co-located within PCMH practices during all practice hours.	List of practitioners and licensure performing services at PCMH sites; Behavioral health practice schedules
2	Develop collaborative evidence-based standards of care including medication management and care engagement process.	Regularly scheduled formal meetings are held to develop collaborative care practices.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees
		Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.	Evidence-based practice guidelines; Implementation plan; Policies and procedures for frequency of updates to documentation; Version log
3	Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.	Policies and procedures are in place to facilitate and document completion of screenings.	Screening policies and procedures
		Screenings are documented in Electronic Health Record.	Screenshot of EHR; EHR Vendor documentation
		100% of Individuals receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-9, SBIRT).	Roster of identified patients; Number of screenings completed

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.i (Model 1)**
Project Title	**Integration of primary care and behavioral health services**

Index Score = 39

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
		Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	Sample EHR demonstrating that warm transfers have occurred
4	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.i (Model 2)**
Project Title	**Integration of primary care and behavioral health services**

Index Score = 39

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Co-locate primary care services at behavioral health sites.	PPS has achieve 2014 NCQA Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	List of participating NCQA-certified physicians/practitioners; Certification documentation
		Primary care services are co-located within behavioral Health practices during all practice hours.	List of practitioners and licensure performing services at behavioral health site; behavioral health practice schedules.
2	Develop collaborative evidence-based standards of care including medication management and care engagement process.	Regularly scheduled formal meetings are held to develop collaborative care practices.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees
		Coordinated evidence based care protocols are in place, including a medication management and care engagement process.	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; version log
	Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT)	Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.	Screening procedures included in PCMH policies and procedures; Log demonstrating number of screenings completed
		Screenings are documented in Electronic Health Record.	Screenshot of EHR; EHR Vendor documentation

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.i (Model 2)**
Project Title	**Integration of primary care and behavioral health services**

Index Score = 39

Project Requirement		Metric/Deliverable*	Data Source(s)
3	behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.	100% of Individuals receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-9, SBIRT).	Screenings documented in EHR
		Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	Sample EHR demonstrating that warm transfers have occurred
4	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

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

Index Score = 39

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Implement IMPACT Model at Primary Care Sites.	PPS has implemented IMPACT Model at Primary Care Sites.	Quarterly reports demonstrating successful implementation of project requirements
2	Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	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.	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; version log
		Policies and procedures include process for consulting with Psychiatrist.	Documentation of evidence-based practice guidelines
3	Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.	Electronic Health Records to demonstrate use of Depression Care Manager.
		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.	Evidence of IMPACT model training and implementation experience; Sample EHR demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions

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

Index Score = 39

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
4	Designate a Psychiatrist meeting requirements of the IMPACT Model.	All IMPACT participants in PPS have a designated Psychiatrist.	Register of IMPACT participants and designated psychiatrist; Policies and procedures in place to follow up with care of patients; Electronic Health Record identifying Psychiatrist for eligible patients
5	Measure outcomes as required in the IMPACT Model.	100% of Individuals receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-9, SBIRT).	Roster of screened patients
6	Provide "stepped care" as required by the IMPACT Model.	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.	Documentation of evidence-based practice guidelines for stepped care; Implementation plan
7	Use EHRs or other technical platforms to track all patients engaged in this project.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements
		PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.ii**
Project Title	**Behavioral health community crisis stabilization services**

Index Score = 37

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.	Quarterly reports demonstrating successful implementation of project requirements
2	Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).	Documented diversion guidelines and protocols; Implementation plan; Policies and procedures regarding frequency of updates to guidelines and protocols; Version log
3	Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.	MOU between PPS and MCO and/or evidence of negotiation for coverage of services with MCO
4	Develop written treatment protocols with consensus from participating providers and facilities.	Regularly scheduled formal meetings are held to develop consensus on treatment protocols.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees
		Coordinated treatment care protocols are in place.	Documentation of protocols and guidelines; Written training materials; list of training dates along with number of staff trained
	Include at least one hospital with specialty	PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider	Network Provider List

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.ii**
Project Title	**Behavioral health community crisis stabilization services**

Index Score = 37

Project Requirement		Metric/Deliverable*	Data Source(s)
5	psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Access plan specific to psychiatric and crisis-oriented services; Access improvement plan; Access reports (including geographic access and service wait time reports)
6	Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.	Network Provider List
		PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Access plan specific to psychiatric and crisis-oriented services; Access improvement plan; Access reports (including geographic access and service wait time reports)
7	Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.	Network Provider List
		Coordinated evidence-based care protocols for mobile crisis teams are in place.	Documentation of care protocols; implementation plan; Written training materials; List of training dates along with number of staff trained

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.ii**
Project Title	**Behavioral health community crisis stabilization services**

Index Score = 37

Project Requirement		Metric/Deliverable*	Data Source(s)
8	Share EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements
		EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); Sample of transactions to public health registries; Use of DIRECT secure email transactions
		Alerts and secure messaging functionality are used to facilitate crisis intervention services.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; Written training materials; List of training dates along with number of staff trained in use of alerts and secure messaging
9	Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	PPS has implemented central triage service among psychiatrists and behavioral health providers.	Operating agreements or policies and procedures related to triage services; reports demonstrating triage performance; Written training materials; List of training dates along with number of staff trained

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.ii**
Project Title	**Behavioral health community crisis stabilization services**

Index Score = 37

Project Requirement		Metric/Deliverable*	Data Source(s)
10	Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. *Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.*	Quality committee membership list with indication of organization represented and staff category, if applicable
		Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes
		PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.ii**
Project Title	**Behavioral health community crisis stabilization services**

Index Score = 37

Project Requirement		Metric/Deliverable*	Data Source(s)
		PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.	Documentation of self-audits, including list of medical records audited, audit criteria, and results of audit
		Service and quality outcome measures are reported to all stakeholders including PPS quality committee.	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes; reports to PPS quality committee.
11	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.iii**
Project Title	**Implementation of Evidence-Based Medication Adherence Program in Community Based Sites for Behavioral Health Medication Compliance**

Index Score = 29

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Develop a medication adherence program to improve behavioral health medication compliance through culturally-competent health literacy initiatives including methods based on the Fund for Public Health NY's Medication Adherence Project (MAP).	PPS has an active medication adherence program which includes initiatives reflecting the Fund for Public Health NY's MAP.	Quarterly reports demonstrating successful implementation of project requirements
		Project staff and participants receive training on PPS medication adherence program initiatives, either utilizing MAP materials or similar materials developed by the PPS.	Written training materials; list of training dates along with number of staff trained
2	Form care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists who are engaged with the behavioral health	PPS has assembled care teams focused on evidence-based medication adherence, including primary care and behavioral health practitioners as well as supporting practitioners, care managers, and others.	List of participating practitioners and individuals participating in the medication adherence care teams with roles and/or provider type indicated
		Regularly scheduled formal meetings are held to develop and update operational protocols based on evidence-based medication adherence standards.	Documented operational protocols; Meeting schedule; Meeting agenda; Meeting minutes; List of attendees

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.iii**
Project Title	**Implementation of Evidence-Based Medication Adherence Program in Community Based Sites for Behavioral Health Medication Compliance**

Index Score = 29

Project Requirement		Metric/Deliverable*	Data Source(s)
	population.	PPS conducts follow-up evaluations to determine patient outcomes and progress towards therapy goals, including evaluation of appropriateness, effectiveness, safety and drug interactions, and adherence where applicable.	Roster of identified patients; Screenshot of EHR; EHR Vendor documentation
3	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)
		EHR for individual patients includes medication information, drug history, allergies and problems, and treatment plans with expected duration.	Sample EHR demonstrating inclusion of medication in patient record; Screenshot of EHR; EHR Vendor documentation
4	Coordinate with Medicaid Managed Care Plans to improve medication adherence.	PPS has engaged MCO to develop protocols for coordination of services under this project.	Written agreements; MOU between PPS and MCO and/or evidence of negotiation for coverage of services with MCO

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.iv**
Project Title	**Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs**

Index Score = 36

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Develop community-based addiction treatment programs that include outpatient SUD sites with PCP integrated teams, and stabilization services including social services.	PPS has developed community-based addiction treatment programs that include outpatient SUD sites, PCP integrated teams, and stabilization services.	Quarterly reports demonstrating successful implementation of project requirements
2	Establish referral relationships between community treatment programs and inpatient detoxification services with development of referral protocols.	PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	Network provider list; Written agreements
		Regularly scheduled formal meetings are held to develop collaborative care practices among community treatment programs as well as between community treatment programs and inpatient detoxification facilities.	Meeting schedule; Meeting agendas; Meeting minutes; List of attendees

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.iv**
Project Title	**Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs**

Index Score = 36

Project Requirement		Metric/Deliverable*	Data Source(s)
		Coordinated evidence based care protocols are in place for community withdrawal management services. Protocols include referral procedures.	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; Version log
3	Include a project medical director, board certified in addiction medicine, with training and privileges for use of buprenorphine and buprenorphine/naltrexone as well as familiarity with other withdrawal management agents.	PPS has designated at least one qualified and certified physician with training and privileges for use of buprenorphine/Naltrexone and other withdrawal agents.	CV; Contract
4	Identify and link to providers approved for outpatient medication management of opioid addiction who agree to provide continued maintenance therapy and collaborate with the treatment program and care manager. These may include practices with collocated behavioral health services, opioid treatment programs or outpatient SUD clinics.	PPS has established relationships between inpatient detoxification services and community treatment programs that have the capacity to provide withdrawal management services to target patients.	Network provider list; Written agreements

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.iv**
Project Title	**Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs**

Index Score = 36

Project Requirement		Metric/Deliverable*	Data Source(s)
5	Develop community-based withdrawal management (ambulatory detoxification) protocols based upon evidence based best practices and staff training.	Coordinated evidence based care protocols are in place for community withdrawal management services.	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; Version log
		Staff are trained on community-based withdrawal management protocols and care coordination procedures.	Written training materials; List of training dates along with number of staff trained
6	Develop care management services within the SUD treatment program.	Coordinated evidence based care protocols are in place for care management services within SUD treatment program.	Documentation of evidence-based care management guidelines; Implementation plan
		Staff are trained to provide care management services within SUD treatment program.	Written training materials; List of training dates along with number of staff trained
7	Form agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	PPS has engaged MCO to develop protocols for coordination of services under this project.	Written agreements; MOU between PPS and MCO and/or evidence of negotiation for coverage of services with MCO

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.iv**
Project Title	**Development of Withdrawal Management (e.g., ambulatory detoxification, ancillary withdrawal services) capabilities and appropriate enhanced abstinence services within community-based addiction treatment programs**

Index Score = 36

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
8	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.v**
Project Title	**Behavioral Interventions Paradigm (BIP) in Nursing Homes**

Index Score = 40

Project Requirement		Metric/Deliverable*	Data Source
1	Implement BIP Model in Nursing Homes model using SNF skilled nurse practitioners (NP) and psychiatric social workers to provide early assessment, reassessment, intervention, and care coordination for at risk residents to reduce the risk of crisis requiring transfer to higher level of care.	PPS has implemented BIP Model in Nursing Homes meeting project requirements.	Quarterly reports demonstrating successful implementation of project requirements
2	Augment skills of the clinical professionals in managing behavioral health issues.	The PPS has trained clinical professionals in Skilled Nursing Facilities to provide BIP program services and applicable behavioral interventions.	Written training materials; List of training dates along with number of staff trained
3	Enabling the non-clinical staff to effectively interact with a behavioral population	The PPS is training non-clinical staff in identifying early signs of behavioral health issues.	Written training materials; List of training dates along with number of staff trained
4	Assign a NP with Behavioral Health Training as a coordinator of care.	The PPS has assigned a NP with Behavioral Health Training as a coordinator of care.	Evidence of employment; CV; NP scheduling or patient log
		Resources have been assigned to Behavior Team as part of Behavior Management interdisciplinary Team; PPS has a description of structure and function of behavior team.	Resource list; Standard Clinical Protocol and Treatment Plan that addresses interdisciplinary care and roles of team members

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.v**
Project Title	**Behavioral Interventions Paradigm (BIP) in Nursing Homes**

Index Score = 40

Project Requirement		Metric/Deliverable*	Data Source
5	Implement a Behavior Management Interdisciplinary Team Approach to care.	Regularly scheduled formal meetings are held to develop interdisciplinary team care protocols.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees
		Interdisciplinary care standards are in place, specifically including interdisciplinary behavior management protocols and practices.	Interdisciplinary care standards; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; Version log
		Interdisciplinary team staff have been trained on interdisciplinary protocols.	Written training materials; List of training dates along with number of staff trained
6	Implement a medication reduction and reconciliation program.	PPS monitors medication administration to identify opportunities for medicaid reduction, especially where early behavioral interventions can be used to prevent use of medication.	Documentation of trends in medication use and response to trends, such as documentation to demonstrate revised medication administration protocols
		PPS has developed medication reconciliation program.	Process flow diagrams demonstrating medication reconciliation processes; Written training materials; List of training dates along with number of staff trained

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.v**
Project Title	**Behavioral Interventions Paradigm (BIP) in Nursing Homes**

Index Score = 40

Project Requirement		Metric/Deliverable*	Data Source
7	Increase the availability of psychiatric and psychological services via telehealth and urgently available providers.	PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures).	Access plan specific to psychiatric and psychological services; Access improvement plan; Access reports (including geographic access and service wait time reports)
		PPS offers telehealth services for SNF patients where access to psychiatric and psychological services is limited.	Telehealth utilization records documented in HER
8	Provide holistic psychological Interventions.	The PPS has defined the types of behavioral health services that are provided, factors that will make the services holistic, and plan to hire or train staff to provide holistic interventions.	Policies and procedures and program description
9	Provide enhanced recreational services.	PPS has increased availability of recreational services.	Recreation log including dates and participants; description of recreational services; budget demonstrating recreational service expenses;
10	Develop crisis intervention strategies via development of an algorithm for staff	PPS has developed crisis intervention program for facilities that includes appropriately trained staff.	Crisis Intervention Plan
		PPS has developed an algorithm for interventions.	Crisis intervention protocols developed by PPS

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.v**
Project Title	**Behavioral Interventions Paradigm (BIP) in Nursing Homes**

Index Score = 40

Project Requirement		Metric/Deliverable*	Data Source
	intervention and utilization of sitter services.	Staff are trained on crisis intervention strategies.	Written training materials; List of training dates along with number of staff trained
		PPS uses sitter services for crisis intervention where necessary.	Sitter utilization reports; schedules of staff designated as sitters
11	Improve documentation and communication re: patient status.	PPS documents patient status in patient health record, including behavioral health interventions and medication use.	Protocols for medical record documentation, particularly including behavioral health interventions and medication reconciliation
		PPS provides periodic training on documentation of patient status and best practices communicating patient status to multidisciplinary care team and patient.	Written training materials; List of training dates along with number of staff trained
12	Modify the facility environment.	PPS has made evidence-based changes to facility environment to promote behavioral health.	Description of changes to environment with justification based on evidence-based environmental improvements; narrative or pictures identifying physical changes; budget demonstrating facility environment modification expenses

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.a.v**
Project Title	**Behavioral Interventions Paradigm (BIP) in Nursing Homes**

Index Score = 40

Project Requirement		**Metric/Deliverable***	**Data Source**
13	Form agreements with the Medicaid Managed Care organizations (including MLTC and FIDA plans) serving the affected population to provide coverage for the service array under this project.	PPS has engaged MCO to develop protocols for coordination of services under this project.	Written agreements; MOU between PPS and MCO and/or evidence of negotiation for coverage of services with MCO
14	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Quarterly reports demonstrating successful implementation of project requirements
2	Actively share EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions
		PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
3	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification; DURSA certification
		PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	Certification documentation

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
4	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)
5	Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	PPS has implemented an automated or workdriver scheduling system to facilitate tobacco control protocols.	Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system; Periodic self-audit reports and recommendations
		PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	List of training dates along with number of staff trained; Written training materials
6	Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Practice has adopted treatment protocols aligned with national guidelines, such a the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).	Policies and procedures related to standardized treatment protocols for hypertension and elevated cholesterol; List of training dates along with number of staff trained; Written training materials; signed agreement with PPS organizations to implement consistent standardized treatment protocols

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
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.	Clinically Interoperable System is in place for all participating providers.	Contract; Report; Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system
		Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Care coordination team rosters; Care coordination policies and procedures; Standard clinical protocol and treatment plans
		Care coordination processes are in place.	Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained
8	Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Policies and procedures related to blood pressure checks; Roster of patients, by PCP practice, who have received follow-up blood pressure checks
9	Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	Policies and procedures; List of training dates along with number of staff trained, if applicable

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

Index Score = 30

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
10	Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Risk assessment tool documentation; Risk assessment screenshots: Patient stratification report; Documented protocols for patient follow-up
		PPS has implemented an automated or workdriver scheduling system to facilitate scheduling of targeted hypertension patients.	Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system
		PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	List of training dates along with number of staff trained; Written training materials
Improve Medication Adherence			
11	Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiatng factors.	Policies and procedures
Optimize Patient Reminders and Supports:			
12	Document patient driven self-management goals in the medical record and review with	Self-management goals are documented in the clinical record.	Documentation of self audit of de-identified medical records over project timeframe demonstrating self-management goals documented in the clinical record

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
	patients at each visit.	PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	List of training dates along with number of staff trained; Written training materials
13	Follow up with referrals to community based programs to document participation and behavioral and health status changes.	PPS has developed referral and follow-up process and adheres to process.	Policies and Procedures including warm transfer protocols
		PPS provides periodic training to staff on warm referral and follow-up process.	List of training dates along with number of staff trained; Written training materials
		Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Written attestation or evidence of agreement; Documentation of process and workflow including responsible resources at each stage of the workflow
14	Develop and implement protocols for home blood pressure monitoring with follow up support.	PPS has developed and implements protocols for home blood pressure monitoring.	Policies and procedures
		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.	Policies and procedures; Log of blood pressure follow-up contacts; Documentation of process and workflow including responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
		PPS provides periodic training to staff on warm referral and follow-up process.	List of training dates along with number of staff trained; Written training materials
15	Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	PPS has implemented an automated or workdriver scheduling system to facilitate scheduling of targeted hypertension patients.	Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system; Roster of identified patients
16	Facilitate referrals to NYS Smoker's Quitline.	PPS has developed referral and follow-up process and adheres to process.	Policies and Procedures including warm transfer protocols
17	Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	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.	REAL dataset; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained; Periodic self-audit reports and recommendations
		If applicable, PPS has established linkages to health homes for targeted patient populations.	Written attestation or evidence of agreement; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
		If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Written attestation or evidence of agreement with community partners; List of training dates along with number of staff trained; Written training materials
18	Adopt strategies from the Million Lives Campaign.	Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Lives Campaign.	Policies and procedures; Log of blood pressure follow-up contacts; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials
19	Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cesssation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Written attestation or evidence of agreement
20	Engage a majority (at least 80%) of primary care practices in this project.	PPS has engaged at least 80% of their PCPs in this activity. (By Year One)	List of total PCPs in the PPS; List of PCPs engaged in this activity

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

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

Index Score = 26

	Project Requirement	Metric/Deliverable*	Data Source(s)
1	Implement or expand evidence-based self-management programs such as the Stanford Chronic Disease Self-Management Program (CDSMP) to address chronic disease specific to cardiovascular diseases.	PPS has partnered with community resources to promote evidence-based self-management strategies (CDSMP), such as: - wellness navigators to assist patients in accessing health services - flexible wellness account system to be used for patients to purchase wellness-related items - evidence-based training to people assisting patients	Written attestation or evidence of agreement with community partners; List of training dates along with number of staff trained; Written training materials
2	Establish protocols to refer patients with HTN or at high risk for onset of hypertension to community-based self-management programs.	PPS has trained staff to facilitate referrals to community partners and provide supports and follow-up to patients referred to community-based initiatives. PPS periodically conducts audits to ensure that referrals are made and partnerships are established.	List of training dates along with number of staff trained; Written training materials; Documentation of process and workflow including responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations
3	Monitor progress of referred patients and make ongoing recommendations with community-based self-management programs.		

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

Index Score = 26

Project Requirement		Metric/Deliverable*	Data Source(s)
4	Ensure comprehensive nutrition standards to improve the nutritional quality of foods served, including reducing sodium, for PPSs that that serve food to employees, patients and/or the public.	PPS adheres to AHA Dietary Guidelines for all foods served by implementing standards for foods purchased and/or training for staff preparing foods onsite.	Policies and Procedures; Periodic self-audit reports and recommendations; List of training dates along with number of staff trained; Written training materials
5	Develop Health Home patient referral protocols to ensure patients receive the appropriate level of care management.	PPS has policies and procedures and process in place for referral to and collaboration with Health Homes.	Documentation of process and workflow including responsible resources at each stage of the workflow
		PPS has trained staff to determine when referral to a Health Home is appropriate and to follow referral processes established by the PPS.	Written training materials; List of training dates along with number of staff trained
6	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Implement evidence based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	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.	Disease management protocols; Documentation of process and workflow including responsible resources at each stage of the workflow; List of training dates along with number of staff trained; Written training materials; Periodic self-audit reports and recommendations
2	Engage at least 80% of primary care practices within the PPS in the implementation of disease management evidence-based best practices.	PPS has engaged at least 80% of their PCPs in this activity. (By Year One)	List of total PCPs in the PPS. List of PCPs engaged in this activity
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,	Clinically Interoperable System is in place for all participating providers.	Contract; Report; Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system
		Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Care coordination team rosters; Care coordination policies and procedures; Standard clinical protocol and treatment plans

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
	and patient self-management.	Care coordination processes are established and implemented.	Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained
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.	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.	REAL dataset; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained; Periodic self-audit reports and recommendations
		If applicable, PPS has established linkages to health homes for targeted patient populations.	Written attestation or evidence of agreement; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
		If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Written attestation or evidence of agreement with community partners; List of training dates along with number of staff trained; Written training materials
5	Ensure coordination with the Medicaid Managed Care organizations serving the target population.	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.	Written attestation or evidence of agreement
6	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)
		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.	Recall report; Roster of identified patients; Screenshots of recall system

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

Index Score = 30

Project Requirement		Metric/Deliverable*	Data Source(s)
7	Meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification; DURSA certification
		PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	Certification documentation
		EHR meets connectivity to RHIO/SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); Sample of transactions to public health registries; Use of DIRECT secure email transactions

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

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

Index Score = 26

Project Requirement		Metric/Deliverable*	Data Source(s)
1	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.	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).	Written attestation or evidence of agreement with community program delivery sites; evidence that CDC-recognized NDPP, CDSMP, and DSME, has been implemented; List of training dates along with number of staff trained; Written training materials
2	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)
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.	PPS has identified patients and referred them to either institutional or community NDPP delivery sites.	Roster of patients with evidence of which NDPP sites they have been referred

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

Index Score = 26

Project Requirement		Metric/Deliverable*	Data Source(s)
4	Ensure collaboration with PCPs and program sites to monitor progress and provide ongoing recommendations.	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).	List of training dates along with number of staff trained; Written training materials; Documentation of process and workflow including responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations; Evidence that referrals and follow-up is conducted.
5	Establish lifestyle modification programs including diet, tobacco use, and exercise and medication compliance.	Lifestyle modification programs that focus on lifestyle modification are created and implemented as part of care plan. Program recommendations are consistent with community resources.	Care need plans; Evidence that program recommendations are consistent with community resources

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

Index Score = 26

Project Requirement		Metric/Deliverable*	Data Source(s)
6	Ensure coordination with Medicaid Managed Care organizations and Health Homes for eligible/involved patients.	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.	Written attestation or evidence of agreement

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.d.i**
Project Title	**Development of evidence-based medication adherence programs (MAP) in community settings – asthma medication**

Index Score = 29

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Implement a medication adherence project (MAP) specific to asthma medication in participating PCP and community settings.	PPS implemented a comprehensive Medication Adherence Program utilizing the Fund for Public Health in New York and NYC Health methodology, and participating staff are trained.	Training dates, materials, and number of staff attending; Documentation of process and workflow including responsible resources at each stage of the workflow
2	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.d.i**
Project Title	**Development of evidence-based medication adherence programs (MAP) in community settings – asthma medication**

Index Score = 29

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
3	Identify and engage care teams, including primary care and specialist practitioners, care managers (including Health Home care managers), social workers, and pharmacists to deliver services to patients with asthma health issues.	PPS developed a comprehensive medication coordination management plan that includes the resources assigned to areas including, but not limited to: 1. Development of personalized care plan with specific therapy goals 2. Coordination of behavioral health and substance abuse care medication and medical/surgical medication regimen as well as medical / surgical health conditions and care needs 3. Follow-up evaluation to determine patient outcomes and progress towards therapy goals; including evaluation of appropriateness, effectiveness, safety and drug interactions, and adherence 4. Coordination of patient medical record, including: Drug history, including allergies and problems, treatment plans with expected medication duration	Develop a Library of Material for PPS care teams; Care coordination teams include 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.
4	Ensure coordination with Medicaid Managed Care organizations.	PPS has established agreements with MCOs that address the coverage of patients with asthma health issues.	Written agreements

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

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

Index Score = 31

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self management education for the appropriate control of asthma.	Documented agreements with partners to provide patient home assessment services; Patient educational materials; Rosters demonstrating that patient has received home-based interventions
2	Establish procedures to provide, coordinate, or link the client to resources for evidence based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence based trigger reduction interventions.	Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials; List of training dates along with number of staff trained; Patient educational materials
3	Develop and implement evidence based asthma management guidelines.	PPS incorporates evidence based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.	Standard Clinical Protocol and Treatment Plan; Evidence that guidelines are reviewed and revised

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

Index Score = 31

Project Requirement		Metric/Deliverable*	Data Source(s)
4	Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Patient educational materials; Rosters demonstrating patient training
5	Ensure coordinated care for asthma patients includes social services and support.	PPS has developed and conducted training of all providers, including social services and support.	Care coordination team rosters; Written training materials; List of training dates along with number of staff trained
		All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Contract; Report; Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system
		PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Documentation of process and workflow including responsible resources at each stage of the workflow

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

Index Score = 31

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
6	Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.	Rosters demonstrating follow-up is conducted; Materials supporting that root cause analysis was conducted, and shared with family
7	Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.	Written agreements
8	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.d.iii**
Project Title	**Implementation of evidence-based medicine guidelines for asthma management**

Index Score = 31

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Implement evidence based asthma management guidelines between primary care practitioners, specialists, and community based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.	PPS has agreements from participating providers and community programs to support a evidence based asthma management guidelines.	Written agreements; Identification of participating providers affiliation with Regional Asthma Coalition
		All participating practices have a Clinical Interoperability System in place for all participating providers.	Contract; Report; Vendor System Documentation, if applicable; Other Sources demonstrating implementation of the system.
		Agreements with asthma specialists and asthma educators are established.	Written agreements; Evidence of methodology used to establish a patient to physician ratio
		EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); sample of transactions to public health registries; use of DIRECT secure email transactions

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.d.iii**
Project Title	**Implementation of evidence-based medicine guidelines for asthma management**

Index Score = 31

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
2	Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services that would benefit - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability	Standard Clinical Protocols and Treatment Plan; List of telemedicine sites; Roster of telemedicine use
3	Deliver educational activities addressing asthma management to participating primary care providers.	Participating providers receive training in evidence-based asthma management.	Written training materials; list of training dates along with number of staff trained

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.d.iii**
Project Title	**Implementation of evidence-based medicine guidelines for asthma management**

Index Score = 31

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
4	Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.	PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with participating health home care managers, PCPs, and specialty providers.	Written agreements with MCOs; Written agreements with Health Homes
5	Use EHRs or other technical platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.e.i (Model 1)**
Project Title	**Comprehensive project to decrease HIV/AIDS transmission—development of Center of Excellence management of HIV/AIDS**

Index Score = 28

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Develop a consulting/referral/educational relation with a center of excellence for management of HIV/AIDS that ensures early access to and retention in HIV and HCV Care – Scatter Model; ensure medical and behavioral health consultation expertise are available.	PPS has conducted CNA and identified community resource gaps and target patient population.	Community Need Assessment; Narrative Description of the Project submitted with the Project Plan Application
		PPS demonstrates that it is providing a consulting/referral/educational relation with a center of excellence for management of HIV/AIDS that ensures early access to and retention in HIV and HCV Care – Scatter Model.	Signed agreement of collaboration between the PPS and an HIV/AIDS COE; Quarterly Reports demonstrating successful implementation of project requirements
		PPS demonstrates that it is making available medical and behavioral health consultation expertise.	Documentation showing an agreement between the PPS and mental/behavioral health provider(s)
2	Identify primary care providers who have significant case loads of patients infected with HIV.	PPS has identified primary care providers with significant case loads of patients infected with HIV using EHR/medical records.	List of PCPs; Volume of HIV patients being treated
3	Implement training for primary care providers which will include consultation resources from the center of excellence.	PPS has implemented training aimed at increasing disease-specific expertise, with consultation from COE. PPS shows evidence that it considered adopting the Project Echo methodology.	Written educational materials; Description of the methodology adopted; List of training dates along with number of staff trained

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.e.i (Model 1)**
Project Title	**Comprehensive project to decrease HIV/AIDS transmission—development of Center of Excellence management of HIV/AIDS**

Index Score = 28

Project Requirement		Metric/Deliverable*	Data Source(s)
4	Develop coordination of care services with behavioral health and social services within or linking with the primary care providers' offices.	All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Screen shots, a list of sites connected to the Clinical Interoperability System, and, if applicable, system vendor documentation
		PPS has care coordinators located or linked to each site PCP site. The PPS utilized the CNA to determine the patient:care coordinator ratio. Care coordinators associated with Health homes have been engaged.	List of sites with care coordinators; Number of coordinators at each site
5	Ensure systems are in place that address patient partnerships to care, ensure follow-up and retention in care, and promote adherence to medication management, monitoring and other requirements of evidence based practice for management of HIV/AIDS.	PPS has developed a system that ensures that patients are reminded for care follow-up, that monitors and promotes adherence to medication management, and offers other components of evidence based practice for management of this infection.	Workflow materials; System screen shots; evidence that patients are being connected to caregivers; prescription scripts given to patients; educational materials provided to patients that describe features of the system and how they can gain access
		PPS has created a quality committee that is representative of PPS staff involved in quality improvement processes and other stakeholders.	Quality committee membership list with indication of organization represented and staff category, if applicable

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.e.i (Model 1)**
Project Title	**Comprehensive project to decrease HIV/AIDS transmission—development of Center of Excellence management of HIV/AIDS**

Index Score = 28

Project Requirement		Metric/Deliverable*	Data Source(s)
6	Institute a system to monitor quality of care with educational services where gaps are identified.	Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes
		PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in listed in Attachment J Domain 3 HIV/AIDS.	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans
		Service and quality outcome measures are reported to all stakeholders.	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes
7	Use EHRs or other IT platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.e.i (Model 2)**
Project Title	**Comprehensive project to decrease HIV/AIDS transmission—development of Center of Excellence management of HIV/AIDS**

Index Score = 28

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Identify site location for a Center of Excellence (COE) which would provide access to the population infected with HIV (and/or HCV).	PPS has conducted a CNA to assist in identifying community resource gaps, a targeted patient population, along with a site location for a Center of Excellence Management for HIV/AIDs (including HCV).	Community Need Assessment; Narrative Description of the Project submitted with the Project Plan Application, and a description of the plan to locate a site for the COE for HIV/AIDs (including HCV)
2	Co-locate at this site services generally needed for this population including primary care, specialty care, dental care, behavioral health services, dietary services, high risk prenatal care and buprenorphine maintenance treatment.	Within the Center of Excellence Management for HIV/AIDs (including HCV), the PPS has developed plans to co-locate services generally needed for this population including primary care, specialty care, dental care, behavioral health services, dietary services, high risk prenatal care and buprenorphine maintenance treatment. This site also offers prevention services such as PREP for high risk, uninfected persons.	Attestation: PPS attestation to co-locate services generally needed for the HIV/AIDs (including HCV) population and prevention services for high risk, uninfected persons. Rosters evidencing treatment for the HIV/AIDs (including HCV) population, by primary care, specialty care, dental care, behavioral health services, dietary services, high risk prenatal care and buprenorphine maintenance treatment. Visit counts of prevention services such as PREP for high risk, uninfected persons

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.e.i (Model 2)**
Project Title	**Comprehensive project to decrease HIV/AIDS transmission—development of Center of Excellence management of HIV/AIDS**

Index Score = 28

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
3	Co-locate care management services including Health Home care managers for those eligible for Health Homes.	The PPS has developed plans to co-locate care management services including Health Home care managers for those eligible for Health Homes at this site.	Attestation: PPS attestation to co-locate care management services at this site. Number of care managers, delineated by health home and non-health home care managers
4	Develop a referral process and connectivity for referrals is developed for those persons who qualify for but are not yet in a Health Home.	A referral process and connectivity for referrals has been developed for those persons who qualify for but are not yet in a Health Home.	Process and Procedures for referring persons who qualify but not yet assigned to a health home
5	Ensure understanding and compliance with evidence based guidelines for management of HIV/AIDS (and HCV)	For all COE staff, PPS has developed training on evidence-based guidelines derived from NIH/HRSA/CDC materials.	Staff training materials derived from NIH/HRSA/CDC references; Training dates and number of staff trained

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.e.i (Model 2)**
Project Title	**Comprehensive project to decrease HIV/AIDS transmission—development of Center of Excellence management of HIV/AIDS**

Index Score = 28

Project Requirement		Metric/Deliverable*	Data Source(s)
6	Ensure coordination of care between all available services preferably through a single electronic health/medical/care management record.	PPS has ensured coordination of care between all available services either through a single electronic health/medical/care management record, or some other self-identified process. The record or process addresses linkage to care, ensures follow-up and retention in care, and promotes adherence to medication management, monitoring and other components of evidence-based practice for management of this infection.	EHR or other IT platforms, vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging; workflow on how this tool will be utilized within PPS
		EHR or other IT platforms meet connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); Sample of transactions to public health registries; Use of DIRECT secure email transactions
		EHR or other IT platforms, meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.e.i (Model 2)**
Project Title	**Comprehensive project to decrease HIV/AIDS transmission—development of Center of Excellence management of HIV/AIDS**

Index Score = 28

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
7	Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms, with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.	EHR or other IT platforms meet connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); Sample of transactions to public health registries; Use of DIRECT secure email transactions
		PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
8	Ensure that EHR systems or other IT platforms, used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.	EHR or other IT platforms, meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification; DURSA certification
		PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	Certification documentation
9	Use EHRs or other IT platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.e.i (Model 2)**
Project Title	**Comprehensive project to decrease HIV/AIDS transmission—development of Center of Excellence management of HIV/AIDS**

Index Score = 28

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
10	Seek designation as center of excellence from New York State Department of Health.	PPS has sought COE designation either by achieving certification (such as Joint Commission Disease-Specific Care Certification) or self-designating based on rigorous standards.	Certification received from a nationally recognized entity as COE, or some evidence-based standards that support the PPS assertion that it merits COE designation

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.f.i (Model 1)**
Project Title	**Increase support programs for maternal and child health (including high risk pregnancies)**

Index Score = 32

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.	PPS has developed a project plan that includes a timeline for implementation of an evidence-based home visiting model, such as Nurse-Family Partnership visitation model, for this population.	Project plan containing a timeline; Quarterly reports containing updates of progress achieved
2	Develop a referral system for early identification of women who are or may be at high risk.	PPS has developed a referral system for early identification of women who are or may be at high risk.	Policies and procedures for a referral system for this population; Workflow; Roster; Documentation showing how shared with management and community
		Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Quality committee membership list with indication of organization represented and staff category, if applicable

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.f.i (Model 1)**
Project Title	**Increase support programs for maternal and child health (including high risk pregnancies)**

Index Score = 32

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
3	Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.	Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes
		PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in listed in Attachment J Domain 3 Perinatal Care Metrics.	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans
		Service and quality outcome measures are reported to all stakeholders.	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes
4	Use EHRs or other IT platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.f.i (Model 2)**
Project Title	**Increase support programs for maternal and child health (including high risk pregnancies)**

Index Score = 32

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Identify and engage a regional medical center with expertise in management of high risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).	PPS has identified and engaged with a regional medical center to address the care of high risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center). Assessment of the volume of high risk pregnancies to be obtained through the CNA.	Signed agreement of collaboration between the PPS and a regional medical center to address this targeted population. Documentation that demonstrates that the affiliated medical center has Level 3 NICU services or is a designated Regional Perinatal Center
2	Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high risk mother and infant with local community obstetricians and pediatric providers.	PPS has assembled a team of experts, including the number and type of experts and specialists and roles in the multidisciplinary team, to address the management of care of high risk mothers and infants.	Documentation listing the team of experts, including the number and type of experts and specialists and description of roles in the multidisciplinary team. Meeting dates and minutes. Clinical quality improvement action plan; Follow-up evaluation of action plans
		PPS has established MOUs or joint operating agreements with substantive multidisciplinary team responsible for co-managing care of high risk mothers and infants.	MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.f.i (Model 2)**
Project Title	**Increase support programs for maternal and child health (including high risk pregnancies)**

Index Score = 32

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
3	Develop service MOUs between multidisciplinary team and OB/GYN providers.	PPS has identified and established MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers.	MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers
4	Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.	PPS has developed/adopted uniform clinical protocols guidelines based upon evidence-based standards agreed to by all partners.	Clinical Guidelines and agreements from all partners
		PPS has established best practice guidelines, policies and procedures, and plans for dissemination and training for interdisciplinary team on best practices.	Documentation of best practice guidelines; Policies and procedures; Plans for dissemination and training for interdisciplinary team
		Training has been completed.	Written training materials; List of training dates along with number of staff trained
	Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms, with local health information	EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); Sample of transactions to public health registries; Use of DIRECT secure email transactions

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.f.i (Model 2)**
Project Title	**Increase support programs for maternal and child health (including high risk pregnancies)**

Index Score = 32

Project Requirement		Metric/Deliverable*	Data Source(s)
5	platforms, with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including secure notifications/messaging, by the end of Demonstration Year 3.	PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging
6	Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.	EHR or other IT platforms meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification
		PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	Certification documentation
7	Use EHRs or other IT platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.f.i (Model 3)**
Project Title	**Increase support programs for maternal and child health (including high risk pregnancies)**

Index Score = 32

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
1	Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.	PPS developed a workplan to use NYSDOH CHW training program and ensure CHW-trained members are integrated into the multidisciplinary team. PPS has obtained DOH funding for CHW training.	Workplan document; training materials; Documentation of roles within multidisciplinary team; Evidence of DOH funding
2	Employ a Community Health Worker Coordinator responsible for supervision of 4 – 6 community health workers. Duties and qualifications are per NYS DOH criteria.	PPS has named assigned CHW Coordinator(s) or timeline for hiring CHW Coordinator(s).	Documentation of job description and hiring of CHW Coordinator(s); Timelines to train and employ; Roster of staff assigned to each CHW

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.f.i (Model 3)**
Project Title	**Increase support programs for maternal and child health (including high risk pregnancies)**

Index Score = 32

Project Requirement		Metric/Deliverable*	Data Source(s)
3	Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.	PPS has developed a CHW workforce strategy and attendant qualifications of CHW(s) who meet the following criteria: 1) Indigenous community resident of the targeted area; 2) Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms; 3) Bilingual skills, depending on the community and families being served; 4) Knowledge of the community, community organizations, and community leaders; 4)Ability to work flexible hours, including evening and weekend hours.	Workplan on CHW workforce strategy; Qualifications included in job description above

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.f.i (Model 3)**
Project Title	**Increase support programs for maternal and child health (including high risk pregnancies)**

Index Score = 32

Project Requirement		Metric/Deliverable*	Data Source(s)
4	Establish protocols for deployment of CHW.	PPS has established timelines to complete protocols (policies and procedures) for CHW program, including methods for new and ongoing training for CHWs.	Workplan showing timelines; Policies and Procedures; Training dates and materials
		PPS has developed plans to develop operational program components of CHW.	Workplan addresses deployment of the CHWs.
5	Coordinate with the Medicaid Managed Care organizations serving the target population.	PPS has established agreements with MCOs demonstrating coordination regarding CHW program, or attestation of intent to establish coverage agreements, as well as progress to date.	Documentation of agreements with MCOs.
6	Use EHRs or other IT platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.g.i**
Project Title	**Integration of palliative care into the PCMH model**

Index Score = 22

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Integrate Palliative Care into appropriate primary care practices that have, or will have, achieved NCQA PCMH certification.	PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH have been included. The PPS has received agreement from those PCPs not PCMH certified to become certified to at least Level 1 of the 2014 NCQA PCMH by Demonstration Year 3.	Roster of participating PCPs, and whether they are NCQA PCMH certified; Agreements with PCPs committing to integrate Palliative Care into their practice model; Agreements with non-PCMH certified PCPs committing to become certified to at least Level 1 of the 2014 NCQA PCMH model
2	Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.	Agreements between the PPS and community and provider resources including Hospice
3	Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.	Clinical Guidelines and agreements from all partners; Training dates, materials, and number of staff attending; Demonstrated use of the MOLST form, where appropriate

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.g.i**
Project Title	**Integration of palliative care into the PCMH model**

Index Score = 22

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
4	Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Staff has received appropriate palliative care skills training, including training on PPS care protocols.	Written training materials; List of training dates along with number of staff trained
5	Engage with Medicaid Managed Care to address coverage of services.	PPS has established agreements with MCOs that address the coverage of palliative care supports and services.	Written agreements
6	Use EHRs or other IT platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.g.ii**
Project Title	**Integration of Palliative Care into Nursing Homes**

Index Score = 25

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Integrate Palliative Care into practice model of participating Nursing Homes.	PPS has integrated palliative care into Nursing Homes in alignment with project requirements.	Roster of participating PCPs, and whether they are NCQA PCMH certified. Agreements with PCPs committing to integrate Palliative Care into their practice model; Quarterly reports demonstrating successful implementation of project requirements
2	Develop partnerships with community and provider resources, including Hospice, to bring the palliative care supports and services into the nursing home.	The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.	Agreements between the PPS and community and provider resources including Hospice
3	Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form.	Clinical Guidelines and agreements from all partners; Demonstrated use of the MOLST form, where appropriate
4	Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Staff has received appropriate palliative care skills training, including training on PPS care protocols.	Written training materials; List of training dates along with number of staff trained

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.g.ii**
Project Title	**Integration of Palliative Care into Nursing Homes**

Index Score = 25

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
5	Engage with Medicaid Managed Care to address coverage of services.	PPS has established agreements with MCOs that address the coverage of palliative care supports and services.	Written agreements
6	Use EHRs or other IT platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.h.i**
Project Title	**Specialized Medical Home(s) for Chronic Renal Failure**

Index Score = 29

Project Requirement		Metric/Deliverable*	Data Source(s)
1	Create a comprehensive “one stop shopping” practice (or practices) to manage patients with chronic renal failure.	PPS has developed a workplan which includes site(s) identification, and cohort of the PPS population to be served by the creation of a special medical home for chronic renal failure.	Workplan; CNA that demonstrates the need and target population for a specialized medical home for chronic renal failure patients
2	Identify a nephrologist champion to develop a specialized medical home for patients with chronic renal failure.	Nephrologist champion has led development or has been significantly involved in development of Specialized Medical Home for Chronic Renal Failure model of care.	Documentation related to the nephrologist champion including: 1) Nephrologist name 2) Nephrologist curriculum vitae (CV) 3) Experience implementing medical home strategies 4) Other information as relevant; Meeting Notes; Meeting agendas
3	Develop coordination partnerships with primary care physicians and practitioners in shared care of complex renal patients.	PPS has identfied primary care physicians/practitioners at each primary care site who express interest in shared care of their complex renal patients.	Network provider list; Written Agreements; Patient : physician ratio of complex renal patients
4	Co-locate services including behavioral health, social services and dialysis at clinic sites.	PPS offers co-locatedbehavioral health, social services and dialysis services to patients with chronic renal failure.	List of each participating site and services offered at each site; Utilization records demonstrating use of services and access to services at each site

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.h.i**
Project Title	**Specialized Medical Home(s) for Chronic Renal Failure**

Index Score = 29

Project Requirement		Metric/Deliverable*	Data Source(s)
5	Adopt evidence based practice guidelines and protocols for patient management.	Evidence-based chronic renal failure management protocols are installed in all PCPs medical homes.	Documentation of process and workflow of evidence based practice guidelines and protocols for patient management, including responsible resources at each stage of the workflow; Evidence of staff education including written training materials; List of training dates along with number of staff trained
6	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 secure notifications/messaging, by the end of Demonstration Year 3.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	DURSA (Data Use and Reciprocal Service Agreement); Sample of transactions to public health registries; Use of DIRECT secure email transactions
		PPS uses alerts and secure messaging functionality.	EHR vendor documentation; Screenshots or other evidence of use of alerts and secure messaging; written training materials; list of training dates along with number of staff trained in use of alerts and secure messaging

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.h.i**
Project Title	**Specialized Medical Home(s) for Chronic Renal Failure**

Index Score = 29

Project Requirement		**Metric/Deliverable***	**Data Source(s)**
7	Ensure EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards by the end of Demonstration Year 3.	EHR meets Meaningful Use stage 1/2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification
		PPS has achieved NCQA Level 3 PCMH standards and/or APCM.	Certification documentation
8	Use EHRs or other IT platforms to track all patients engaged in this project.	PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)
9	Coordinate with the Medicaid Managed Care organizations serving the affected population.	PPS has established agreements with MCOs that address the coverage of complex renal patients.	Written agreements

**Define the specific tasks and timelines necessary to achieve these component metrics. These must reconcile with the implementation timeline certified in the project plan application*