DSRIP QUARTERLY REVIEW PROCESS:

PPSs will submit a quarterly report to the Independent Assessor throughout the DSRIP program via the automated MAPP tool which includes Domain 1 DSRIP Project Requirement Milestone and Metrics. Each Project Requirement includes the time period for completion as well the unit level of reporting which are discussed in further detail below.

Project Requirement - Timeframe

PPSs must enter a target completion date against all Project Requirements Milestone and Metrics. Each Project Requirement has been assigned to one of three time periods for completion. Dates cannot exceed the prescribed time period of speed and scale commitments made in the submitted application (this includes prescribed minimum time periods beyond PPS Application Speed and Scale Commitment). Each of the following requirement sections is similarly color-coded throughout the document.

Project System Changes: Based upon the work plan section in Attachment I, NY DSRIP Program Funding and Mechanics Protocol, no more than the first two years will be utilized to implement major system changes related to the project. Example project requirements that fall into this time period cohort include: training for care coordinators, developing systematic approaches like clinical protocols, the identification of key project personnel, performing population health management activities, or using EHRs or other technical platforms to track patients engaged in the project.

Project Requirements with Specific Time Periods : A number of project requirements include prescribed end dates for achievement. Example project requirements include: safety net providers actively sharing medical records with RHIO/SHIN-NY by the end of DY 3 or PCPs achieving Level 3 PCMH certification by the end of DY 3.

Project Requirements Tied to PPS Speed and Scale Commitments : The due dates for these project requirements are at the discretion of the PPS and should be consistent with commitments each PPS made in the speed and scale sections of the submitted project application. Project requirements within this time period include components like implementing open access scheduling in all PCP practices, deploying a provider notification/secure messaging system, or converting outdated or unneeded hospital capacity into needed community-based services.

Project Requirement - Unit Level Reporting

Project Unit Level Reporting	**Project-Unit Level Reporting** - These are Domain 1 requirement metrics/deliverables which will be reported by the PPS lead at the project-wide level demonstrating the PPS' overall project performance and success. These are requirements not specific to individual provider but rather are requirements that must be organized and administered by the PPS lead through the PPS' participating providers and partners. Some of these requirements include performing population health management activities, monthly meetings with MCOs, establishing partnerships between primary care providers and participating Health Homes, and developing materials meeting the cultural and linguistic needs of the population.
***Provider Unit Level* Reporting**	**Provider-Unit Level Reporting** - These are Domain 1 requirement metrics/deliverables for which performance and success must be demonstrated at the provider level. Some of these requirements include PCPs meeting 2014 NCQA Level 3 PCMH standards, EHR meeting RHIO HIE and SHIN-NY requirements or implementing open access scheduling in PCP practices.

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

Definition of Actively Engaged	Patients residing in counties served by the PPS having completed a RHIO Consent Form (including agreeing or denying consent).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 amongst providers in the IDS**	Provider network list; Periodic reports demonstrating changes to network list; **Contractual agreements.**	Project
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 list of participating HH; Written agreements; Evidence of interaction	Updated list of participating HH; written agreements, evidence of interaction.	Project
		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.	Periodic progress reports on implementation that demonstrate a path to evolve HH or ACO into IDS.	Project
		Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees.	Project

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

Definition of Actively Engaged	Patients residing in counties served by the PPS having completed a RHIO Consent Form (including agreeing or denying consent).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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
		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	Process flow diagrams demonstrating IDS processes	Project
		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	Contract; Report; Periodic reporting of discharge plans uploaded into EHR; Other sources demonstrating implementation of the system	Project
		PPS trains staff on IDS protocols and processes.	Written training materials; list of training dates along with number of staff trained.	Written training materials; list of training dates along with number of staff trained.	Project
4	Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participation agreement; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participation agreement; sample of transactions to public health registries; **use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, Hospital, BH, SNF)
		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	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

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

Definition of Actively Engaged	Patients residing in counties served by the PPS having completed a RHIO Consent Form (including agreeing or denying consent).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
5	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards **and/or APCM** by the end of Demonstration Year 3.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (SN: PCP)
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 sufficiently accurate to conduct population health management)	Sample patient registries; EHR completeness reports (necessary data fields sufficiently accurate to conduct population health management)	Project
7	Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	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	Status reporting of recruitment of PCPs, particularly in high-need areas; Demonstration of improved access via CAHPS measurement	Project
		All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
		EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project

Timeframe previously: Project System Changes

Changed from: Achieve 2014 Level 3 PCMH primary care certification for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.

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

Definition of Actively Engaged	Patients residing in counties served by the PPS having completed a RHIO Consent Form (including agreeing or denying consent).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level	
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	Documentation of executed Medicaid Managed Care contracts; Report demonstrating percentage of total provider Medicaid reimbursement using value-based payments	Project	Timeframe previously: Project System Changes.
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; **Medicaid MCO attendee list**; meeting materials; process of reporting meeting outcomes/recommendations to stakeholders and PPS leadership	Meeting minutes; agendas; **attendee lists**; meeting materials; process of reporting meeting outcomes/recommendations to stakeholders and PPS leadership	Project	
10	Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	~~PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation~~	**VBP Growth Plan**; Compensation model; ~~consultant recommendations~~	Compensation model**; implementation plan**; consultant recommendations	Project	Changed from: PPS has a plan to evolve provider compensation model to incentive-based compensation
		Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Contract; Report; **Payment reconciliation documentation**; Other sources demonstrating implementation of the compensation and performance management system	Contract; Report; **Payment Voucher**; Other sources demonstrating implementation of the compensation and performance management system	Project	Timeframe previously: Project System Changes.
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 of community-based health worker hiring; Co-location agreements between community health workers and CBOs; Job description of the community health workers**; Report on how many patients are engaged with community health worker	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	Project	

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

Definition of Actively Engaged	The number of participating patients who receive preventive care screenings from participating providers to identify unmet medical or behavioral health needs from participating PCPs.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Ensure that all participating PCPs in the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
2	Identify a physician champion with knowledge of PCMH/APCM implementation for each primary care practice included in the project.	PPS has identified physician champion with experience implementing PCMHs/APCMs.	**Role description of the physician champion**; CV (**illustrating** NCQA PCMH certification, PCMH **and/or APCM** content **expertise, and/or significant** population health experience); Contract; **PCMH certification and/or APCM documentation**	**Role description**; CV (explicating NCQA certification, PCMH content expert, population health experience); Contract; **Certifications**	Provider (PCP practice)
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	List of names of care coordinators at each primary care site	Provider (PCP practice)
		Care coordinator identified, site-specific role established as well as inter-location coordination responsibilities.	**Role description of the care coordinator**; Written training materials	**Role descriptions**; Written training materials	Provider (PCP practice)
		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	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

Changed from: Ensure that all participating PCPs the PPS meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.

Project 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

Definition of Actively Engaged	The number of participating patients who receive preventive care screenings from participating providers to identify unmet medical or behavioral health needs from participating PCPs.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
4	Ensure all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions**	Provider (SN: PCP)
		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	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
5	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards **and/or APCM** by the end of Demonstration Year 3.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (SN: PCP)
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 sufficiently accurate to conduct population health management)	~~Sample patient registries;~~ EHR completeness reports (necessary data fields sufficiently accurate to conduct population health management)	Project
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 preventive 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.	Policies and procedures related to standardized treatment protocols for chronic disease management; agreements with PPS organizations to implement consistent standardized treatment protocols.	Project
		Project staff are trained on policies and procedures specific to evidence-based preventive and chronic disease management.	Documentation of training program; Written training materials; List of training dates along with number of staff trained	Documentation of training program; Written training materials; List of training dates along with number of staff trained	Provider (PCP practice)

Timeframe previously: Project System Changes.

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

Definition of Actively Engaged	The number of participating patients who receive preventive care screenings from participating providers to identify unmet medical or behavioral health needs from participating PCPs.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
8	Implement preventive care screening protocols including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) for all patients to identify unmet needs. A process is developed for assuring referral to appropriate care in a timely manner.	Preventive care screenings implemented among participating PCPs, including behavioral health screenings (PHQ-2 or 9, SBIRT).	OQPS Reporting Requirements; claims reporting; number and types of screenings implemented; **number of patients screened**; **number of providers trained on screening protocols**	OQPS Reporting Requirements; claims reporting; number and types of screenings implemented; **numbers of patients screened**; **numbers of providers trained on screening protocols**	Provider (PCP)
		Protocols 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	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
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, which could include a 1.) new patient physical, 2.) routine exam or 3.) return visit exam [Institute for Healthcare Improvement measures];** Response times reporting; **Materials communicating open access scheduling**; **Vendor System Documentation**; Other Sources demonstrating implementation	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	Provider (PCP Practice)
		PCMH 1B After Hours Access scheduling to meet NCQA standards established across all PPS primary care sites.	Scheduling standards documentation; Response times reporting; **Materials communicating open access scheduling**; **Vendor System Documentation**; Other Sources demonstrating implementation	Scheduling Standards Documentation; Response times reporting; **Materials communicating practice hours**; **Vendor System Documentation, if applicable**; Other Sources demonstrating implementation	Provider (PCP Practice)
		PPS monitors and decreases no-show rate by at least 15%.	Baseline no-show rate with periodic reports demonstrating 15% no-show rate reduction	Baseline no-show rate with periodic reports demonstrating 15% no-show rate reduction	Provider (PCP Practice)

Changed from: Preventive care screenings implemented among participating PCPs, including behavioral health screenings (PHQ-9, SBIRT).

Changed from: 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.

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

Definition of Actively Engaged	The number of participating patients who completed a new or updated comprehensive care management plan.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC 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 definition of roles of PCMH/APC 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	Complete strategic plan; Reports on progress in implementation that demonstrate a path to successful implementation within the timeframe committed to in the application	Project
2	Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	All practices meet NCQA 2014 Level 3 PCMH and APCM standards	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)

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

Definition of Actively Engaged	The number of participating patients who completed a new or updated comprehensive care management plan.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
3	Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, HH)
		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	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
4	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Certification documentation	Certification documentation	Provider (SN: PCP)

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

Definition of Actively Engaged	The number of participating patients who completed a new or updated comprehensive care management plan.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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)	Sample patient registries; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project
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 engagement with at-risk patients; Number of patients engaged with care management plan	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	Project
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	Information-sharing policies and procedures; Number of patients provided care management services	Provider (PCP, HH)

Timeframe previously: Project System Changes.

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

Definition of Actively Engaged	The number of participating patients who completed a new or updated comprehensive care management plan.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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; List of active partner providers and agencies**; written agreements with partner providers and agencies; **care coordination processes and services; clinical team's policies and procedures related to group decision-making**	**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**	Provider (PCP, HH)
		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	EHR vendor documentation; protocols for use of EHR vendor documentation for referrals	Project
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 evidence-based practice protocols; Training materials**	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**	Project
		Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Project
		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	Meeting minutes; List of attendees; agreements with social services agencies	Project
		Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.	Educational materials; evaluation of materials for cultural competence	Educational materials; evaluation of materials for cultural competence	Project

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

Definition of Actively Engaged	The number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village in a year.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Complete strategic plan; Reports on progress in implementation that demonstrate a path to successful implementation within the timeframe committed to in the application	Project
		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	Meeting minutes; List of attendees and organizations represented	Project
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**; **Periodic progress reports documenting bed reduction.**	Certificate of Need (CON) for bed reduction; Bed reduction timeline; **Baseline bed capacity and periodic progress reports documenting bed reduction.**	Project
3	Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)

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

Definition of Actively Engaged	The number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village in a year.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
4	Ensure that all safety net providers participating in Medical Villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, Hospitals, BH)
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project
6	Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project (Medical Village Sites)
7	Ensure that services which migrate to a different setting or location (clinic, hospitals, etc.) are 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 regarding frequency of updates to guidelines and protocols**	Migration plan; Justification for migration as evidenced by CNA; Policies and Procedures; **Version Log**	Project

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

Definition of Actively Engaged	The number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village within a year.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 outdated 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.	Implementation plan to provide improved access; Reports on progress in implementation that demonstrate a path to successful implementation.	Project
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.	Implementation Plan; Reports on progress in implementation that demonstrate a path to successful implementation.	Project
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 infrastructure 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	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	Project

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

Definition of Actively Engaged	The number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village within a year.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
4	Provide 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	Documentation of housing access to or integrated supports for elders and persons with disabilities	Project
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	Documentation of new community services available; Baseline outpatient volume with periodic reports demonstrating increase in outpatient visits	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients who had two or more distinct non-emergency services from at least two distinct participating providers at a Medical Village within a year.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
7	Ensure that all participating PCPs meet NCQA 2014 Level 3 PCMH accreditation and/or meet state-determined criteria for Advanced Primary Care Models by the end of DSRIP Year 3.	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
8	Ensure that all safety net providers participating in medical villages are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, SNF, BH)
9	Ensure that EHR systems used in Medical Villages meet Meaningful Use Stage 2	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project (Medical Village sites)

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

Index Score = 36

Definition of Actively Engaged	The number of participating patients who had two or more distinct services at an Ambulatory ICU in a year.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level	
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 adequate specialty resources within the community including medical, behavioral, nutritional, rehabilitation, and other necessary providers to meet the population needs.	**List of participating medical, behavioral, nutritional, rehabilitation, and other necessary providers**; **Evidence of service integration**; documentation of staffing	**List of participating medical, behavioral, nutritional, rehabilitation, and other necessary providers**; **Certification documentation**; documentation of staffing	Project (Ambulatory Sites)	Changed from: PPS has recruited intra- or inter-network specialty resources; evidence of an adequate network of medical; behavioral; nutritional; rehabilitation; and other necessary providers to meet the population needs.
		PPS has established a standard clinical protocol for Ambulatory ICU services.	Standard Clinical Protocol	Standard Clinical Protocol	Project (Ambulatory Sites)	
2	Ensure Ambulatory ICU is integrated with all relevant Health Homes in the community.	Each identified Ambulatory ICU has established partnerships with the local Health Home based on the Nuka Model.	List of participating Health Homes as well as community-based, non-physician participants (including complex specialty services e.g., housing, rehab, etc.)	List of participating Health Homes as well as community-based, non-physician participants (including complex specialty services e.g., housing, rehab, etc.)	Project (Ambulatory Sites)	Changed from: Each identified Ambulatory ICU establish partnerships with the local Health Home based on the Nuka Model
3	Use EHRs and other technical platforms to track all patients engaged in the project, including collecting community data and Health Home referrals.	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)**	**Documentation of Process and System Requirements; documentation of population health logic methodology**	Project	Changed from: Eligible patients have been identified.
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	Documented evidence of health home and social support care managers operating in Ambulatory ICU sites; Attestation	Project (Ambulatory Sites)	

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

Index Score = 36

Definition of Actively Engaged	The number of participating patients who had two or more distinct services at an Ambulatory ICU in a year.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
5	Ensure that all safety net project participants are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including Direct exchange (secure messaging), alerts and patient record look up.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, Hospitals, BH)
		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	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
6	Ensure that EHR systems used by participating providers meet Meaningful Use and PCMH Level 3 standards **and/or APCM**.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (SN: PCP)

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

Index Score = 36

Definition of Actively Engaged	The number of participating patients who had two or more distinct services at an Ambulatory ICU in a year.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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.	**Evidence of portal development and functionality**; **Screenshots of patient communication system**; staff training documentation	**Documented portal functionality**; **Screen Shots of patient communication system**; staff training documentation	Project
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	Documentation of process/procedures and workflow including responsible resources at each stage; Written training materials; List of training dates; Number of staff trained	Project
9	Deploy a provider notification/secure messaging system to alert care managers and Health Homes of important developments in patient care and utilization.	EHR System with Real Time Notification System is in use.	**System design**; **Screenshots of Real Time Notification System**; Training Documentation	**Documented Process**; **Screen Shots of Real Time Notification System**; Training Documentation	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.ii**
Project Title	**Development of Co-Located Primary Care Services in the Emergency Department**

Index Score = 40

Definition of Actively Engaged	The number of participating patients who presented at the ED but were successfully and appropriately redirected to a PCMH/APCM site, after ~~triage~~ medical screening.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Ensure appropriate location of the co-located primary care services in the ED to be located on the same campus of the hospital. All relocated PCMH practices will meet NCQA 2014 Level 3 PCMH standards and/or APCM within 2 years after relocation.	Relocated PCMH practices located in the ED achieve NCQA 2014 Level 3 PCMH standards and/or APCM 2 years after relocation.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation; Evidence of appropriate co-location of primary care services.	List of participating NCQA-certified physicians/practitioners; Certification documentation; Evidence of appropriate co-location of primary care services.	Provider (PCP)
2	Ensure that new participating PCPs 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 participating PCPs must have open access scheduling extended hours, and have EHR capability that is interoperable with the ED.	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
		All new practices meet NCQA 2014 PCMH 1A scheduling standards.	Scheduling standards documentation; **Report showing third next available appointment, which could include a 1.) new patient physical, 2.) routine exam or 3.) return visit exam [Institute for Healthcare Improvement measures]**; Response times reporting; **Materials communicating open access scheduling**; **Vendor System Documentation**	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**	Provider (PCP)
		All new practices meet NCQA 2014 PCMH 1B scheduling standards.	Scheduling standards documentation; **Report showing third next available appointment, which could include a 1.) new patient physical, 2.) routine exam or 3.) return visit exam [Institute for Healthcare Improvement measures]**; Response times reporting; **Materials communicating open access scheduling**; Vendor System Documentation	Scheduling Standards Documentation; report showing third next available appointment (Institute for Healthcare Improvement measures); Response times reporting; **Materials communicating practice hours**; Vendor System Documentation	Provider (PCP)
3	Develop care management protocols for triage and referral to ensure compliance with EMTALA standards.	Care management protocols and procedures, consistent with EMTALA standards, for triage and referral are developed in concert with practitioners at the PCMHs and/or APCM sites and are in place.	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~~	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	Project

Changed from: Ensure EHR utilization including supporting secure notifications/messaging, as well as sharing medical records between the participating **in the** local health providers via Meaningful Use standards.

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.ii**
Project Title	**Development of Co-Located Primary Care Services in the Emergency Department**

Index Score = 40

Definition of Actively Engaged	The number of participating patients who presented at the ED but were successfully and appropriately redirected to a PCMH/APCM site, after ~~triage~~ medical screening.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
4	Ensure utilization of EHR that supports secure notification/messaging and sharing of medical records between participating local health providers, and meets Meaningful Use Stage 2 CMS requirements.	EHR supports secure notifications/messaging and the sharing of medical records.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions.**	Provider (SN: PCP, Hospital)
		EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
5	Establish protocols and training for care coordinators to assist patients in understanding use of the health system, and to 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	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 (co-location site)
6	Implement a comprehensive payment and billing strategy. (The PCP may only bill usual primary care billing codes and not emergency billing codes.)	The PCP bills only primary care, not emergency, billing codes.	Periodic self-audit of procedure codes billed; **payment agreements only allowing non-emergency billing codes**	Periodic self-audit of procedure codes billed; **payment agreements requiring non-emergency**	Project (co-location site)
7	Develop protocols for connectivity to the assigned health plan PCP and real-time notification to the Health Home care manager as applicable.	EHR System with Real Time Notification System is in use.	**Protocols**; **Screenshots of Real Time Notification System**; Training Documentation	**Documented Process**; **Screen Shots of Real Time Notification System**; Training Documentation	Project
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; **Protocols**; Written attestation or evidence of agreement with Community Organizations; Written training materials	Program Budget; **Documented Process**; Written attestation or evidence of agreement with Community Organizations; Written training materials	Project

Project Domain	**System Transformation Projects (Domain 2)**
Project ID	**2.b.ii**
Project Title	**Development of Co-Located Primary Care Services in the Emergency Department**

Index Score = 40

Definition of Actively Engaged	The number of participating patients who presented at the ED but were successfully and appropriately redirected to a PCMH/APCM site, after ~~triage~~ medical screening.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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, which could include a 1.) new patient physical, 2.) routine exam or 3.) return visit exam [Institute for Healthcare Improvement measures]**; Response times reporting; **Materials communicating open access scheduling**; **Vendor System Documentation**; Other Sources demonstrating implementation	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	Provider (PCP)
		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, which could include a 1.) new patient physical, 2.) routine exam or 3.) return visit exam [Institute for Healthcare Improvement measures]**; Response times reporting; **Materials communicating open access scheduling**; **Vendor System Documentation**; Other Sources demonstrating implementation	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	Provider (PCP)
		PPS monitors and decreases no-show rate by at least 15%.	Baseline no-show rate with periodic reports demonstrating 15% no-show rate reduction	Baseline no-show rate with periodic reports demonstrating 15% no-show rate reduction	Provider (PCP)
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Index Score = 43

Definition of Actively Engaged	The number of participating patients presenting to ~~at~~ the ED ~~and appropriately referred for~~, who after medical screening examination ~~and~~ were successfully redirected to a PCP as demonstrated by ~~connection with their Health Home care manager or~~ a scheduled appointment.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Establish ED care triage program for at-risk populations	Stand up program based on project requirements	**Project description & necessary resources and key challenges**	**Status of implementation through Implementation Plan milestones**; **Quarterly Reports**	Project
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 2014 Level 3 PCMH and/or APCM standards.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
		EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
		Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Contract Review of PPS; **Encounter Notification Summary**; Report; **Vendor System Documentation**; Other Sources demonstrating implementation of the system	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	Provider (PCP and Hospital)

Changed from: Encounter Notification Service (ENS) is installed in all PCP and EDs

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

Index Score = 43

Definition of Actively Engaged	The number of participating patients presenting to ~~at~~ the ED ~~and appropriately referred for~~, who after medical screening examination ~~and~~ were successfully redirected to a PCP as demonstrated by ~~connection with their Health Home care manager or~~ a scheduled appointment.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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
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	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	Provider (Hospital)
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients with a care transition plan developed prior to discharge ~~who are not readmitted within that 30-day period.~~

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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.	Documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; **training documentation**	Documentation of process and workflow including responsible resources at each stage of the workflow; written training materials; **completion of training documentation as necessary**	Project
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	Payment Agreements or MOUs with Managed Care Plans	Project
		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	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	Project
		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	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
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	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	Project
4	Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	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	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	Provider (PCP, Non-PCP, Hospitals)
		PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.	Contract; **Vendor System Documentation**; **Documentation demonstrating that the care manager has access to visit their patients in the hospital**	Contract; **Vendor System Documentation, if applicable**; **Other Sources demonstrating case manager access to the system**	Project

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

Definition of Actively Engaged	The number of participating patients with a care transition plan developed prior to discharge ~~who are not readmitted within that 30-day period.~~

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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
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	Policies and Procedures	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients with a care transition plan developed prior to discharge ~~who are not readmitted within that 30-day period~~.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Written agreements; Network provider list	Project
		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	Policies and Procedures; Meeting minutes	Project
2	Engage with the Medicaid Managed Care Organizations and Managed Long Term Care or FIDA Plans associated with their identified population to develop transition of care protocols, ensure covered services including DME will be readily available, and that there is a payment strategy for the transition of care services.	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	Written agreements; Policies and Procedures; Documentation of process and workflow including responsible resources at each stage	Project
		Covered services, including Durable Medical Equipment, are available for the identified population.	Contract; Report; Other sources demonstrating service availability	Contract; Report; Other sources demonstrating service availability	Project
		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	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	Project

Timeframe previously: Project System Changes.

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

Definition of Actively Engaged	The number of participating patients with a care transition plan developed prior to discharge ~~who are not readmitted within that 30-day period~~.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
3	Develop transition of care protocols that will include timely notification of planned discharges and the ability of the SNF staff to visit the patient and staff in the hospital to develop the transition of care services. Ensure that all relevant protocols allow patients in end-of-life situations to transition home with all appropriate services.	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	Documentation of early notification of planned discharge process and workflow including responsible resources at each stage	Provider (PCPs & SNF)
		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	Written agreements; Policies and Procedures	Project
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	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
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.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions.**	Provider (SN: PCP & SNF)
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Index Score = 47

Definition of Actively Engaged	The number of participating patients who utilized transitional supportive housing and were appropriately monitored via telephonic ~~or~~ and face-to-face contact throughout a 90-day transition period to address a specific housing-related need.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 between the PPS and community housing providers and/or home care service organizations**	MOUS; Service agreements; **letters of commitment, other documentation**	Project
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.	**Documentation of protocols**; **Evidence of implementation including person responsible**; priority list for transitioned patients indicating successful transition to permanent housing	**Documentation of protocols and evidence of implementation including person responsible resources at each stage**; priority list for transitioned patients indicating successful transition to permanent housing	Project
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	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	Project
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	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

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

Index Score = 47

Definition of Actively Engaged	The number of participating patients who utilized transitional supportive housing and were appropriately monitored via telephonic ~~or~~ and face-to-face contact throughout a 90-day transition period to address a specific housing-related need.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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
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 2 CMS requirements; Documentation exhibiting timely transfer of patient medical records to patient's PCP and specialists, as appropriate	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
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 provide 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	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
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles as established within the project requirements.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 report narrative demonstrating successful implementation of project requirements**	**Quarterly reports demonstrating successful implementation of project requirements**	Project
		Nursing home to hospital transfers reduced.	Baseline nursing home to hospital transfer volume with periodic reports demonstrating decrease in transfers	Baseline nursing home to hospital transfer volume with periodic reports demonstrating decrease in transfers	Provider (SNF)
		INTERACT 3.0 Toolkit used at each SNF.	**Implementation Plan**	**Evidence of INTERACT 3.0 toolkit use and rationale**	Provider (SNF)
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 of the facility champion**; CV (**explaining** experience with INTERACT principles); Contract; **Individual trained in INTERACT principles identified**	**Role description**; CV (explicating experience with INTERACT principles); Contract; **Certifications**	Provider (SNF)
3	Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Documentation of care pathway and clinical tool(s) methodology	Documentation of care pathway and clinical tool(s) methodology	Project
		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	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
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	List of training dates along with number of staff trained; Written training materials	Provider (SNF)

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

Definition of Actively Engaged	The number of participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles as established within the project requirements.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
5	Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Evidence of tool(s)/Toolkit materials	Evidence of tool(s)/Toolkit materials	Project
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	List of training dates along with number of staff trained; Written training materials	Provider (SNF)
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 education materials**	Patient/family education methodology; **Patient/family involvement methodology**	Project
8	Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
		EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions.**	Provider (SN: PCP & SNF)

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

Definition of Actively Engaged	The number of participating patients who avoided nursing home to hospital transfer, attributable to INTERACT principles as established within the project requirements.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 membership list with indication of organization represented and staff category, if applicable	Project
		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	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes	Project
		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	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans	Project
		Service and quality outcome measures are reported to all stakeholders.	Website URLs with published reports; Newsletters; **Documentation demonstrating quality outcomes**	Website URLs with published reports; Newsletters; **Documentation demonstrating distribution of quality outcomes**	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Index Score = 45

Definition of Actively Engaged	The number of participating patients who avoided home care to hospital transfer, attributable to INTERACT-like principles, as established within the project requirements.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 report narrative demonstrating successful implementation of project requirements**; List of Rapid Response Team staff; Procedures and protocols	**Quarterly reports demonstrating successful implementation of project requirements**; List of Rapid Response Team staff; Procedures and protocols	Project
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 preventive medicine - chronic disease management	List of training dates along with number of staff trained; Written training materials	List of training dates along with number of staff trained; Written training materials	Provider (Home Care Facilities)
		Evidence-based guidelines for chronic-condition management implemented.	Evidence-based practice guidelines; Implementation plan	Evidence-based practice guidelines; Implementation plan	Project
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	Documentation of care pathway and clinical tool(s) methodology	Project
		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	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	Provider (Hospital)
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	List of training dates along with number of staff trained; Written training materials	Provider (Home Care Facilities)

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

Index Score = 45

Definition of Actively Engaged	The number of participating patients who avoided home care to hospital transfer, attributable to INTERACT-like principles, as established within the project requirements.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Evidence of tool(s)/Toolkit materials	Project
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	List of training dates along with number of staff trained; Written training materials	Provider (Home Care Facilities)
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 education materials**	Patient/family education methodology; **Patient/family involvement methodology**	Project
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, pharmacological) integrated into care and medication management model.	**Care coordination methodology**; **List of all participating services**; Medication management methodology	**Care coordination methodology and results**; **Lists of all participating services**; Medication management methodology	Project
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	Implementation plan; Evidence of use of telemedicine services	Project

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

Index Score = 45

Definition of Actively Engaged	The number of participating patients who avoided home care to hospital transfer, attributable to INTERACT-like principles, as established within the project requirements.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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
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 membership list with indication of organization represented and staff category, if applicable	Project
		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	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes	Project
		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	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans	Project
		Service and quality outcome measures are reported to all stakeholders.	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress	Project

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

Index Score = 36

Definition of Actively Engaged	The number of participating patients who are utilizing the OBS services that meet project requirements.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 report narrative demonstrating successful implementation of project requirements**	Opportunity assessment for OBS units; Implementation plan for OBS units; **Quarterly reports demonstrating successful implementation of project requirements**	Provider (Hospital)
		Care coordination is in place for patients routed outside of ED or OBS services.	Care coordination methodology	Care coordination methodology	Project
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	Baseline clinical and financial model, with periodic updates demonstrating gap to clinical and financial goals	Provider (Hospital)
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	Care coordination methodology for safe discharge, with short-stay protocol specifications	Project

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

Index Score = 36

Definition of Actively Engaged	The number of participating patients who are utilizing the OBS services that meet project requirements.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
4	Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including Direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
		EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, Hospital)
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients assisted by community navigators (in-person, telephonic, or web-based).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 report narrative demonstrating successful implementation of project requirements**	**Quarterly reports demonstrating successful implementation of project requirements**	Project
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	Resource guide; List of training dates along with number of staff trained; Written training materials	Project
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 with community navigators**; Evidence of resident/community involvement	List of community navigators; **Contracts**; Evidence of resident/community involvement	Project
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	Strategic plan for navigator placement; List of navigator locations, detailing proximity to community-based organizations and target patients	Project
		Telephonic and web-based health navigator services implemented by type.	Strategic plan for implementation of each navigator service type (in-person, telephonic, web-based)	Strategic plan for implementation of each navigator service type (in-person, telephonic, web-based)	Project

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

Definition of Actively Engaged	The number of participating patients assisted by community navigators (in-person, telephonic, or web-based).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Documentation of partnerships with non-clinical resources	Project
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	Case load and discharge process methodology	Project
7	Market the availability of community-based navigation services.	Health navigator personnel and services marketed within designated communities.	Documentation of comprehensive marketing plan	Documentation of comprehensive marketing plan	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients who receive telemedicine consultations.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 - 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 report narrative demonstrating successful implementation of project requirements**	**Quarterly reports demonstrating successful implementation of project requirements**	Project
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	Equipment specifications; Equipment rationale	Project
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.	Implementation plan with delineated service areas and corresponding providers.	Provider (Hub and Spoke Sites locations)

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

Definition of Actively Engaged	The number of participating patients who receive telemedicine consultations.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Written attestation or evidence of agreement	Provider (Hub and Spoke Sites locations)
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	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	Project
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	Written attestation or evidence of agreement	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of individuals who completed PAM® or other patient engagement techniques.

	Project Requirements	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Contract or partner with community-based organizations (CBOs) to engage target populations using PAM® and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	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 report narrative demonstrating successful implementation of project requirements**	MOUs, contracts, letters of agreement or other partnership documentation; **Quarterly reports demonstrating successful implementation of project requirements**	Project
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.	**Names and roles of team staff trained in PAM® or other patient activation methods; Copy of training materials and trainers**	**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**	Project
3	Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	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	"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	Project
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	List of community forums held, detailing locations, agenda, and presenters; Documentation surveys or other information-gathering techniques	Project
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	List of PPS providers trained in PAM®; Training dates; Written training materials	Project

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

Definition of Actively Engaged	The number of individuals who completed PAM® or other patient engagement techniques.

	Project Requirements	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Documented procedures and protocols; Information-exchange agreements between PPS and MCO	Project
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	Baseline, periodic and annual PAM® cohort reports and presentations	Project
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 in program development and awareness efforts**	**List of contributing patient members participating program development and awareness efforts**	Project

Previously there was no Unit Level provided.

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

Definition of Actively Engaged	The number of individuals who completed PAM® or other patient engagement techniques.

	Project Requirements	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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's score must be averaged to calculate a baseline measure for that year's cohort. ▯ The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. ▯ The PPS will NOT be responsible for assessing the patient via PAM® 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.	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 - 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	Performance measurement reports and presentations; Annual reports; Member engagement lists, by PAM® cohort	Performance measurement reports and presentations; Annual reports; Member engagement lists, by PAM® cohort	Project

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

Definition of Actively Engaged	The number of individuals who completed PAM® or other patient engagement techniques.

	Project Requirements	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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)	Baseline non-emergent volume with periodic reports demonstrating increase in visits (specific to UI, NU, and LU patients)	Project
11	Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Community navigators identified and contracted.	Periodic list of community navigator credentials (by designated area) detailing navigator names, location, and contact information	Periodic list of community navigator credentials (by designated area) detailing navigator names, location, and contact information	Provider (PAM® providers, CBOs)
		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	List of training dates along with number of staff trained; Written training materials	Provider (PAM® providers, CBOs)
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	Documented procedures and protocols	Project
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 of training agenda materials, and team staff roles who will be engaged in patient activation	Description including the following components: the names and roles of team staff trained in PAM®, by whom they were trained, copy of training agenda materials, and team staff roles who will be engaged in patient activation	Provider (PAM® providers, CBOs)

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

Definition of Actively Engaged	The number of individuals who completed PAM® or other patient engagement techniques.

	Project Requirements	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Evidence of navigator placement by location	Provider (PAM® providers, CBOs)
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; **List of the PPS trainers**; Training dates; Written training materials	List of navigators trained by PPS; **Names of PPS trainers**; Training dates; Written training materials	Project
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 the PPS**	Policies and procedures for intake and/or scheduling staff to receive navigator calls; **List of provider intake staff trained by PPS**	Project
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 sufficiently accurate to conduct population health management)	Sample patient registries; EHR completeness reports (necessary data fields sufficiently accurate to conduct population health management)	Project

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

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
		Behavioral health services are co-located within PCMH/APC practices and are available.	List of practitioners and licensure performing services at PCMH **and/or APCM** sites; Behavioral health practice schedules	List of practitioners and licensure performing services at PCMH sites; Behavioral health practice schedules	Provider (BH)
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	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Project
		Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.	Evidence-based practice guidelines; Implementation plan; **Policies and procedures regarding frequency of updates to guidelines and protocols**	Evidence-based practice guidelines; Implementation plan; Policies and procedures for frequency of updates to documentation; **Version log**	Project

Changed from: Behavioral health services are co-located within PCMH practices are available during all practice hours.

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

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
3	Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Policies and procedures are in place to facilitate and document completion of screenings.	Screening policies and procedures	Screening policies and procedures	Project
		Screenings are documented in Electronic Health Record.	**Screenshots or other evidence of notifications of patient identification and screening alerts**; EHR Vendor documentation	**Screenshot of EHR**; EHR Vendor documentation	Project
		At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	Roster of identified patients; Number of screenings completed	Roster of identified patients; Number of screenings completed	Project
		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	Sample EHR demonstrating that warm transfers have occurred	Provider (PCP)
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	Sample EHR demonstrating both medical and behavioral health Project Requirements	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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

Changed from: Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients to identify unmet needs.

Changed from: 100% of Individuals receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-9, SBIRT).

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

Index Score = 39

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Co-locate primary care services at behavioral health sites.	PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP);** Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
		Primary care services are co-located within behavioral Health practices and are available.	List of practitioners and licensure performing services at behavioral health site; behavioral health practice schedules.	~~List of practitioners and licensure performing services at behavioral health site; behavioral health practice schedules.~~	Provider (PCP, BH)
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	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Project
		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	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; **version log**	Project

Changed from: Primary care services are co-located within behavioral Health practices are available during all practice hours.

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

Index Score = 39

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
3	Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.	Screening **protocols** included in policies and procedures; **Log demonstrating the number of screenings completed**	Screening **procedures** ~~included in PCMH~~ policies and procedures; **Log demonstrating number of screenings completed**	Project
		Screenings are documented in Electronic Health Record.	**Screenshots or other evidence of notifications of patient identification and screening alerts**; EHR Vendor documentation	**Screenshot of EHR**; EHR Vendor documentation	Project
		At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	Screenings documented in EHR	Screenings documented in EHR	Project
		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	Sample EHR demonstrating that warm transfers have occurred	Provider (PCP)
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	Sample EHR demonstrating both medical and behavioral health Project Requirements	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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	

Changed from: Conduct preventive care screenings, including behavioral health screenings (PHQ-9, SBIRT) implemented for all patients

Changed from: 100% of Individuals receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-9, SBIRT).

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

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Implement IMPACT Model at Primary Care Sites.	PPS has implemented IMPACT Model at Primary Care Sites.	**Quarterly report narrative demonstrating successful implementation of project requirements**	**Quarterly reports demonstrating successful implementation of project requirements**	Provider (PCP Practices)
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	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; **version log**	Project
		Policies and procedures include process for consulting with Psychiatrist.	Documentation of evidence-based practice guidelines	Documentation of evidence-based practice guidelines	Project
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.	**Identification of Depression Care Manager via Electronic Health Records**	**Identification of Depression Care Manager; via Electronic Health Records**	Project
		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**; Sample EHR demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions	**Evidence of IMPACT model training and implementation experience**; Sample EHR demonstrating relapse prevention plans, patient coaching, and other IMPACT interventions	Project

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

Definition of Actively Engaged	The total ~~of~~ number of patients engaged ~~per~~ in each of the three models in this project, including: A. PCMH/APC Service Site: Number of patients receiving appropriate preventive care screenings that include mental health/SA. ~~Number of patients screened (PHQ-9 / SBIRT)~~ B. Behavioral Health Site: Number of patients receiving primary care services at a participating mental health or substance abuse site. C. IMPACT: Number of patients screened (PHQ-2 or 9 / SBIRT).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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	Project
5	Measure outcomes as required in the IMPACT Model.	At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).	Roster of screened patients	Roster of screened patients	Project
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	Documentation of evidence-based practice guidelines for stepped care; Implementation plan	Project
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	Sample EHR demonstrating both medical and behavioral health Project Requirements	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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

Changed from: 100% of Individuals receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-9, SBIRT).

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

Index Score = 37

Definition of Actively Engaged	Participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 report narrative demonstrating successful implementation of project requirements**	**Quarterly reports demonstrating successful implementation of project requirements**	Project (By Crisis Site)
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 management guidelines and protocols**; Implementation plan; Policies and procedures regarding frequency of updates to guidelines and protocols	**Documented diversion guidelines and protocols**; Implementation plan; Policies and procedures regarding frequency of updates to guidelines and protocols; **Version log**	Project
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	MOU between PPS and MCO and/or evidence of negotiation for coverage of services with MCO	Project
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	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Project
		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	Documentation of protocols and guidelines; Written training materials; list of training dates along with number of staff trained	Project
5	Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network	Participating Provider List	Participating Provider List	Project
		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)	Access plan specific to psychiatric and crisis-oriented services; Access improvement plan; Access reports (including geographic access and service wait time reports)	Provider (Hospital)

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

Index Score = 37

Definition of Actively Engaged	Participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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.	Participating Provider List	Participating Provider List	Project
		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)	Access plan specific to psychiatric and crisis-oriented services; Access improvement plan; Access reports (including geographic access and service wait time reports)	Provider (Hospital, BH, Clinic)
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.	Roster of mobile crisis team	Roster of mobile crisis team	Project (Mobile Crisis Teams)
		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	Documentation of care protocols; implementation plan; Written training materials; List of training dates along with number of staff trained	Project (Mobile Crisis Teams)

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

Index Score = 37

Definition of Actively Engaged	Participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
8	Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	EHR demonstrates integration of medical and behavioral health record within individual patient records.	Sample EHR demonstrating both medical and behavioral health Project Requirements	Sample EHR demonstrating both medical and behavioral health Project Requirements	Project
		EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; Sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; Sample of transactions to public health registries; **Use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, Hospital, BH)
		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	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
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**; **Policies and procedures related to triage services**; reports demonstrating triage performance; Written training materials; List of training dates along with number of staff trained	**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

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

Index Score = 37

Definition of Actively Engaged	Participating patients receiving crisis stabilization services from participating sites, as determined in the project requirements.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 membership list with indication of organization represented and staff category, if applicable	Project
		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	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes	Project
		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	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans	Project
		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	Documentation of self-audits, including list of medical records audited, audit criteria, and results of audit	Project
		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.	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes; reports to PPS quality committee.	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Index Score = 29

Definition of Actively Engaged	The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Develop a medication adherence program to improve behavioral health medication adherence 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 report narrative demonstrating successful implementation of project requirements**	**Quarterly reports demonstrating successful implementation of project requirements**	Project
		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 roster of staff trained	Written training materials; list of training dates along with roster of staff trained	Project
2	Form care teams including practitioners, care managers including Health Home care managers, social workers and pharmacists who are engaged with the behavioral health population.	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	List of participating practitioners and individuals participating in the medication adherence care teams with roles and/or provider type indicated	Project
		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	Documented operational protocols; Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Provider (PCP, Non-PCP, BH)
		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; **Screenshots indicating potential medication issue**; EHR Vendor documentation	Roster of identified patients; **Screenshot of EHR**; EHR Vendor documentation	Project

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

Index Score = 29

Definition of Actively Engaged	The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project
		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; **Screenshots of medication history and treatment plans**; EHR Vendor documentation	Sample EHR demonstrating inclusion of medication in patient record; **Screenshot of EHR**; EHR Vendor documentation	Project
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	Written agreements; MOU between PPS and MCO and/or evidence of negotiation for coverage of services with MCO	Project

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

Definition of Actively Engaged	The number of patients who have received outpatient withdrawal management services at participating sites.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 report narrative demonstrating successful implementation of project requirements**	**Quarterly reports demonstrating successful implementation of project requirements**	Project
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.	List of hospitals and community treatment programs with detox services; Written agreements	List of hospitals and community treatment programs with detox services; Written agreements	Provider (BH, SA, Hospital)
		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	Meeting schedule; Meeting agendas; Meeting minutes; List of attendees	Project
		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	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; **Version log**	Project
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 of the qualified and certified physician**; Contract	**CV**; Contract	Project

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

Definition of Actively Engaged	The number of patients who have received outpatient withdrawal management services at participating sites.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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.	List of identified providers approved for outpatient med management and clinics/hospital detox sites they work at; Written agreements	List of identified providers approved for outpatient med management and clinics/hospital detox sites working at; Written agreements	Provider (PCP, Non-PCP, Hospital, SA, BH)
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	Documentation of evidence-based practice guidelines; Implementation plan; Policies and procedures regarding frequency of updates to evidence-based practice documentation; **Version log**	Project
		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	Written training materials; List of training dates along with number of staff trained	Project

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

Definition of Actively Engaged	The number of patients who have received outpatient withdrawal management services at participating sites.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Documentation of evidence-based care management guidelines; Implementation plan	Project
		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	Written training materials; List of training dates along with number of staff trained	Project
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	Written agreements; MOU between PPS and MCO and/or evidence of negotiation for coverage of services with MCO	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Index Score = 40

Definition of Actively Engaged	The number of participating patients impacted by program initiatives (bed census).

	Project Requirement	Metric/Deliverable	Data Source	Old Data Source(s)	Unit Level
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	Quarterly reports demonstrating successful implementation of project requirements	Provider (SNF)
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	Written training materials; List of training dates along with number of staff trained	Project
3	Enable the non-clinical staff to effectively interact with a behavioral population	The PPS has trained non-clinical staff in identifying early signs of behavioral health issues.	Written training materials; List of training dates along with number of staff trained	Written training materials; List of training dates along with number of staff trained	Project
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 of the NP assigned as a coordinator of care**; NP scheduling or patient log	Evidence of employment; **CV**; NP scheduling or patient log	Provider (SNF)

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

Index Score = 40

Definition of Actively Engaged	The number of participating patients impacted by program initiatives (bed census).

Project Requirement		Metric/Deliverable	Data Source	Old Data Source(s)	Unit Level
5	Implement a Behavior Management Interdisciplinary Team Approach to care.	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; Treatment Plan that addresses interdisciplinary care; Roles of team members**	Resource list; **Standard Clinical Protocol and Treatment Plan that addresses interdisciplinary care and roles of team members**	Project
		Regularly scheduled formal meetings are held to develop interdisciplinary team care protocols.	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Meeting schedule; Meeting agenda; Meeting minutes; List of attendees	Project
		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 guidelines and protocols**	Interdisciplinary care standards; Implementation plan; **Policies and procedures regarding frequency of updates to evidence-based practice documentation; Version log**	Project
		Interdisciplinary team staff have been trained on interdisciplinary protocols.	Written training materials; List of training dates along with number of staff trained	Written training materials; List of training dates along with number of staff trained	Project
6	Implement a medication reduction and reconciliation program.	PPS monitors medication administration to identify opportunities for medication 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	Documentation of trends in medication use and response to trends, such as documentation to demonstrate revised medication administration protocols	Project
		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	Process flow diagrams demonstrating medication reconciliation processes; Written training materials; List of training dates along with number of staff trained	Project
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)	Access plan specific to psychiatric and psychological services; Access improvement plan; Access reports (including geographic access and service wait time reports)	Project
		PPS offers telehealth services for SNF patients where access to psychiatric and psychological services is limited.	Telehealth utilization records documented in Electronic Health Records	Telehealth utilization records documented in Electronic Health Records	Project

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

Index Score = 40

Definition of Actively Engaged	The number of participating patients impacted by program initiatives (bed census).

Project Requirement		Metric/Deliverable	Data Source	Old Data Source(s)	Unit Level
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.	**Project description & necessary resources and staff recruitment and training**	**Policies and procedures and program description**	Project
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;	Recreation log including dates and participants; description of recreational services; budget demonstrating recreational service expenses;	Project
10	Develop crisis intervention strategies via development of an algorithm for staff intervention and utilization of sitter services.	PPS has developed crisis intervention program for facilities that includes appropriately trained staff.	Crisis Intervention Plan	Crisis Intervention Plan	Project
		PPS has developed an algorithm for interventions.	Crisis intervention protocols developed by PPS	Crisis intervention protocols developed by PPS	Project
		Staff are trained on crisis intervention strategies.	Written training materials; List of training dates along with number of staff trained	Written training materials; List of training dates along with number of staff trained	Project
		PPS uses sitter services for crisis intervention where necessary.	Sitter utilization reports; schedules of staff designated as sitters	Sitter utilization reports; schedules of staff designated as sitters	Project

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

Index Score = 40

Definition of Actively Engaged	The number of participating patients impacted by program initiatives (bed census).

Project Requirement		Metric/Deliverable	Data Source	Old Data Source(s)	Unit Level
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	Protocols for medical record documentation, particularly including behavioral health interventions and medication reconciliation	Project
		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	Written training materials; List of training dates along with number of staff trained	Project
12	Modify the facility environment.	PPS has made evidence-based changes to facility environment to promote behavioral health.	**Description of changes to the facility environment with justification based on evidence-based environmental improvements;** narrative or pictures identifying physical changes; budget demonstrating facility environment modification expenses	**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	Provider (SNF)
13	Formal 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	Written agreements; MOU between PPS and MCO and/or evidence of negotiation for coverage of services with MCO	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 report narrative demonstrating successful implementation of project requirements**	**Quarterly reports demonstrating successful implementation of project requirements**	Project
2	Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; sample of transactions to public health registries; **use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, BH)
		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	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
3	Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices;** Certification documentation	Provider (PCP)
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project
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 work driver scheduling system to facilitate tobacco control protocols.	**Vendor System Documentation;** Other Sources demonstrating implementation of the system; Periodic self-audit reports and recommendations	**Vendor System Documentation, if applicable;** Other Sources demonstrating implementation of the system; Periodic self-audit reports and recommendations	Project
		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	List of training dates along with number of staff trained; Written training materials	Project

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

Definition of Actively Engaged	The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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
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**; Other Sources demonstrating implementation of the system	Contract; Report; **Vendor System Documentation, if applicable**; Other Sources demonstrating implementation of the system	Project
		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 team rosters; Care coordination policies and procedures; Standard clinical protocol and treatment plans	Project
		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	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
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	Policies and procedures related to blood pressure checks; Roster of patients, by PCP practice, who have received follow-up blood pressure checks	Provider (PCP Practice)
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	Policies and procedures; List of training dates along with number of staff trained, if applicable	Project
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 output;** Documented protocols for patient follow-up	Risk assessment tool documentation; Risk assessment screenshots: **Patient stratification report;** Documented protocols for patient follow-up	Project
		PPS has implemented an automated or work driver scheduling system to facilitate scheduling of targeted hypertension patients.	**Vendor System Documentation;** Other Sources demonstrating implementation of the system	**Vendor System Documentation, if applicable**; Other Sources demonstrating implementation of the system	Project
		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	List of training dates along with number of staff trained; Written training materials	Project

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

Definition of Actively Engaged	The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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-differentiating factors.	Policies and procedures	Policies and procedures	Project
Optimize Patient Reminders and Supports:					
12	Document patient driven self-management goals in the medical record and review with patients at each visit.	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	Documentation of self audit of de-identified medical records over project timeframe demonstrating self-management goals documented in the clinical record	Project
		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	List of training dates along with number of staff trained; Written training materials	Project

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

Definition of Actively Engaged	The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 of referral process including warm transfer protocols	Policies and Procedures including warm transfer protocols	Project
		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	List of training dates along with number of staff trained; Written training materials	Project
		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	Written attestation or evidence of agreement; Documentation of process and workflow including responsible resources at each stage of the workflow	Project
14	Develop and implement protocols for home blood pressure monitoring with follow up support.	PPS has developed and implemented protocols for home blood pressure monitoring.	Policies and procedures	Policies and procedures	Project
		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; **Baseline home blood pressure monitoring and periodic updates exhibiting an increase of monitoring**; Documentation of process and workflow including responsible resources at each stage of the workflow; Periodic self-audit reports and recommendations	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
		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	List of training dates along with number of staff trained; Written training materials	Project

Changed from: PPS has developed and implements protocols for home blood pressure monitoring.

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

Definition of Actively Engaged	The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 work driver scheduling system to facilitate scheduling of targeted hypertension patients.	**Vendor System Documentation**; Other Sources demonstrating implementation of the system; Roster of identified patients	**Vendor System Documentation, if applicable**; Other Sources demonstrating implementation of the system; Roster of identified patients	Project
16	Facilitate referrals to NYS Smoker's Quitline.	PPS has developed referral and follow-up process and adheres to process.	Policies and Procedures of referral process including warm transfer protocols	Policies and Procedures including warm transfer protocols	Project
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	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	Project
		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	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
		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	Written attestation or evidence of agreement with community partners; List of training dates along with number of staff trained; Written training materials	Project

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

Definition of Actively Engaged	The number of participating patients receiving services from participating providers with documented self-management goals in medical record (diet, exercise, medication management, nutrition, etc.).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
18	Adopt strategies from the Million Hearts Campaign.	Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Policies and procedures; **Baseline home blood pressure monitoring and periodic updates exhibiting an increase of monitoring**; Documentation of process and workflow including responsible resources at each stage of the workflow; Written training materials	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	Provider (PCP, Non PCP, BH)
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 cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Written attestation or evidence of agreement	Written attestation or evidence of agreement	Project
20	Engage a majority (at least 80%) of primary care providers in this project.	PPS has engaged at least 80% of their PCPs in this activity.	List of total PCPs in the PPS; List of PCPs engaged in this activity	List of total PCPs in the PPS; List of PCPs engaged in this activity	Provider (PCP)

Changed from: PPS has engaged at least 80% of their PCPs in this activity. (By Year One)

Timeframe previously: Project Requirements Tied to PPS Speed and Scale Commitments

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

Definition of Actively Engaged	The number of participating patients with at least one hemoglobin A1c test within the previous Demonstration Year (DY).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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	Project
2	Engage at least ~~80% of~~ primary care providers 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.	List of total PCPs in the PPS; List of PCPs engaged in this activity	List of total PCPs in the PPS. List of PCPs engaged in this activity	Provider (PCP)
3	Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	Clinically Interoperable System is in place for all participating providers.	Contract; Report; **Vendor System Documentation**; Other Sources demonstrating implementation of the system	Contract; Report; ~~Vendor System~~ **Documentation, if applicable**; Other Sources demonstrating implementation of the system	Project
		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 team rosters; Care coordination policies and procedures; Standard clinical protocol and treatment plans	Project
		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	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

Changed from: PPS has engaged at least 80% of their PCPs in this activity. (By Year One)

Timeframe previously: Project Requirements Tied to PPS Speed and Scale Commitments

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

Definition of Actively Engaged	The number of participating patients with at least one hemoglobin A1c test within the previous Demonstration Year (DY).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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	Project
		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	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
		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	Written attestation or evidence of agreement with community partners; List of training dates along with number of staff trained; Written training materials	Project
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	Written attestation or evidence of agreement	Project

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

Definition of Actively Engaged	The number of participating patients with at least one hemoglobin A1c test within the previous Demonstration Year (DY).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project
		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	Recall report; Roster of identified patients; Screenshots of recall system	Project
7	Meet Meaningful Use and PCMH Level 3 standards **and/or APCM** by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.	EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	**Meaningful Use certification from CMS or NYS Medicaid or EHR Proof of Certification**	**Meaningful Use certification from CMS or NYS Medicaid**	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
		EHR meets connectivity to RHIO/SHIN-NY requirements.	QE participant agreements; Sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; Sample of transactions to public health registries; **Use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, BH)

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.c.ii**
Project Title	**Implementation of evidence-based strategies in the community to address chronic disease-primary and secondary prevention strategies (adult only).**

Index Score = 26

Definition of Actively Engaged	The number of participating patients participating in programs at project site.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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, have been implemented; List of training dates along with number of staff trained; Written training materials	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	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project
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	Roster of patients with evidence of which NDPP sites they have been referred	Project
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 are conducted.	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 are conducted.	Provider (PCP, Non-PCP, BH)
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 needs plans; Evidence that program recommendations are consistent with community resources	Care need plans; Evidence that program recommendations are consistent with community resources	Project

Project Domain	**Clinical Improvement Projects (Domain 3)**
Project ID	**3.c.ii**
Project Title	**Implementation of evidence-based strategies in the community to address chronic disease-primary and secondary prevention strategies (adult only).**

Index Score = 26

Definition of Actively Engaged	The number of participating patients participating in programs at project site.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Written attestation or evidence of agreement	Project

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

Definition of Actively Engaged	The number of participating patients based on home assessment log, patient registry, or other IT platform.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Documented agreements with partners to provide patient home assessment services; Patient educational materials; Rosters demonstrating that patient has received home-based interventions	Project
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	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	Project
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	Standard Clinical Protocol and Treatment Plan; Evidence that guidelines are reviewed and revised	Project
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	Patient educational materials; Rosters demonstrating patient training	Project

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

Definition of Actively Engaged	The number of participating patients based on home assessment log, patient registry, or other IT platform.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Care coordination team rosters; Written training materials; List of training dates along with number of staff trained	Project
		All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Contract; Report; Vendor System Documentation; Other Sources demonstrating implementation of the system	Contract; Report; Vendor System Documentation, **if applicable**; Other Sources demonstrating implementation of the system	Project
		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	Documentation of process and workflow including responsible resources at each stage of the workflow	Project
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	Rosters demonstrating follow-up is conducted; Materials supporting that root cause analysis was conducted, and shared with family	Project
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	Written agreements	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients with asthma action plan.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Written agreements; Identification of participating providers affiliation with Regional Asthma Coalition	Project
		All participating practices have a Clinical Interoperability System in place for all participating providers.	Contract; Report; Vendor System Documentation; Other Sources demonstrating implementation of the system.	Contract; Report; Vendor System Documentation, **if applicable**; Other Sources demonstrating implementation of the system.	Provider (PCP, Non-PCP)
2	Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	Agreements with asthma specialists and asthma educators are established.	Written agreements; Evidence of methodology used to establish a patient to physician ratio	Written agreements; Evidence of methodology used to establish a patient to physician ratio	Project
		EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; sample of transactions to public health registries; **Evidence** of DIRECT secure email transactions	QE participant agreements; sample of transactions to public health registries; **use** of DIRECT secure email transactions	Provider (SN: PCP, Non-PCP)
		Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability	Standard clinical protocols and treatment plan; List of telemedicine sites; **Evidence of telemedicine implementation (claims, screenshots, or service agreements)**	Standard Clinical Protocols and Treatment Plan; List of telemedicine sites; **Roster of telemedicine use**	Project
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	Written training materials; list of training dates along with number of staff trained	Project

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

Definition of Actively Engaged	The number of participating patients with asthma action plan.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Written agreements with MCOs; Written agreements with Health Homes	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients who received and filled at least ~~four~~ two sequential anti-viral prescription scripts within the previous Demonstration Year (DY).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 Needs Assessment; Narrative description of the Project submitted with the Project Plan Application	Community Need Assessment; Narrative Description of the Project submitted with the Project Plan Application	Project
		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 report narrative demonstrating successful implementation of project requirements**	Signed agreement of collaboration between the PPS and an HIV/AIDS COE; **Quarterly Reports demonstrating successful implementation of project requirements**	Project
		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)	Documentation showing an agreement between the PPS and mental/behavioral health provider(s)	Project
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	List of PCPs; Volume of HIV patients being treated	Providers (PCP)
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	Written educational materials; Description of the methodology adopted; List of training dates along with number of staff trained	Project

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

Definition of Actively Engaged	The number of participating patients who received and filled at least ~~four~~ two sequential anti-viral prescription scripts within the previous Demonstration Year (DY).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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.	**A list of sites connected to the Clinical Interoperability System; System vendor documentation**	**Screen shots, a list of sites connected to the Clinical Interoperability System, and, if applicable, system vendor documentation**	Providers (PCP Practice, Clinics)
		PPS has care coordinators located or linked to each 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	List of sites with care coordinators; Number of coordinators at each site	Providers (PCP Practice, Clinics)
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 screenshots demonstrating: - Evidence that patients are being connected to caregivers - Prescription given to patients - Educational materials provided to patients that describe features of the system and how they can gain access	Workflow materials; System screen shots demonstrating: - Evidence that patients are being connected to caregivers - Prescription given to patients - Educational materials provided to patients that describe features of the system and how they can gain access	Project

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

Definition of Actively Engaged	The number of participating patients who received and filled at least ~~four~~ two sequential anti-viral prescription scripts within the previous Demonstration Year (DY).

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
6	Institute a system to monitor quality of care with educational services where gaps are identified.	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	Quality committee membership list with indication of organization represented and staff category, if applicable	Project
		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	Quality improvement plans; Root cause analysis, Implementation Reports; Implementation results; Meeting minutes	Project
		PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 HIV/AIDS.	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans	Project
		Service and quality outcome measures are reported to all stakeholders.	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients who received and filled at least ~~four~~ two sequential anti-viral prescription scripts within the previous Demonstration Year (DY).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 Needs Assessment; **Description of the plan to locate a site for the COE 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)**	Project
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 (Pre-Exposure Prophylaxis) 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	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 (By Program Site)
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.	PPS updates of co-locating care management services at sites; Number of care managers, delineated by health home and non-health home care managers	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	Project (By Program Site)

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

Definition of Actively Engaged	The number of participating patients who received and filled at least ~~four~~ two sequential anti-viral prescription scripts within the previous Demonstration Year (DY).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
4	Develop a referral process and connectivity for referrals of people 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 for but are not yet assigned to a Health Home	Process and Procedures for referring persons who qualify but not yet assigned to a health home	Project
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 NYS AIDS Institute, NIH/HRSA/CDC materials.	**Staff training materials derived from NYS AIDS Institute, NIH/HRSA/CDC references**; Training dates and number of staff trained	Staff training materials derived from NIH/HRSA/CDC references; Training dates and number of staff trained	Project
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.	Evidence of coordination of care functionality within 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; workflow on how this tool will be utilized within a PPS	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	Project
		EHR or other IT platforms meet connectivity to RHIO's HIE and SHIN-NY requirements.	QE participation agreements; Sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participation agreements; Sample of transactions to public health registries; **Use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, BH)
		EHR or other IT platforms, meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification from CMS or NYS Medicaid	Meaningful Use certification from CMS or NYS Medicaid	Project

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

Definition of Actively Engaged	The number of participating patients who received and filled at least ~~four~~ two sequential anti-viral prescription scripts within the previous Demonstration Year (DY).

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 direct exchange (secure messaging), alerts and patient record look ups, by the end of DY 3.	EHR or other IT platforms meet connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; Sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; Sample of transactions to public health registries; **Use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, BH)
		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	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
8	Ensure that EHR systems or other IT platforms, used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards **and/or APCM** by the end of Demonstration Year 3.	EHR or other IT platforms, meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification from CMS or NYS Medicaid	Meaningful Use certification from CMS or NYS Medicaid	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project
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 designating the PPS as a COE, or some evidence-based standards that support the PPS assertion that it merits COE designation**	**Certification received from a nationally recognized entity as COE, or some evidence-based standards that support the PPS assertion that it merits COE designation**	Project

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

Definition of Actively Engaged	The number of expecting mothers and mothers participating in this program.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 report narrative containing updates of progress achieved**	Project plan containing a timeline; **Quarterly reports containing updates of progress achieved**	Project
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; **Evidence exhibiting that high-risk women identified are shared with relevant PPS partners**	Policies and procedures for a referral system for this population; Workflow; Roster; **Documentation showing how shared with management and community**	Project
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.	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 membership list with indication of organization represented and staff category, if applicable	Project
		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	Quality improvement plans; Root cause analysis; Implementation Reports; Implementation results; Meeting minutes	Project
		PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Perinatal Care Metrics.	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans	Meeting minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans	Project
		Service and quality outcome measures are reported to all stakeholders.	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes	Website URLs with published reports; Newsletters; Other documentation demonstrating distribution of quality outcomes	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of expecting mothers and mothers participating in this program.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	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	Project
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: team of experts, number and type of experts and specialists, and description of roles**; Meeting dates and minutes; Clinical quality improvement action plan; Follow-up evaluation of action plans	**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	Project
		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	MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers	Project
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	MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers	Project

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

Definition of Actively Engaged	The number of expecting mothers and mothers participating in this program.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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; Agreements from all partners**	**Clinical Guidelines and agreements from all partners**	Project
		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	Documentation of best practice guidelines; Policies and procedures; Plans for dissemination and training for interdisciplinary team	Project
		Training has been completed.	Written training materials; List of training dates along with number of staff trained	Written training materials; List of training dates along with number of staff trained	Project
5	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 direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	QE participant agreements; Sample of transactions to public health registries; **Evidence of DIRECT secure email transactions**	QE participant agreements; Sample of transactions to public health registries; **Use of DIRECT secure email transactions**	Provider (SN: PCP, Non-PCP, Clinic)
		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	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

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

Definition of Actively Engaged	The number of expecting mothers and mothers participating in this program.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
6	Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	EHR or other IT platforms meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Meaningful Use certification from CMS or NYS Medicaid	Meaningful Use certification from CMS or NYS Medicaid	Project
		PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	**List of participating NCQA-certified and/or APC-approved physicians/practioners (APC Model requirements as determined by NY SHIP)**; Certification documentation	**List of participating NCQA-certified practices**; Certification documentation	Provider (PCP)
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of expecting mothers and mothers participating in this program.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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 work plan 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.	Work plan document; training materials; Documentation of roles within multidisciplinary team; Evidence of DOH funding	Work plan document; training materials; Documentation of roles within multidisciplinary team; Evidence of DOH funding	Project
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	Documentation of job description and hiring of CHW Coordinator(s); Timelines to train and employ; Roster of staff assigned to each CHW	Project
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; 5)Ability to work flexible hours, including evening and weekend hours.	Workplan on CHW workforce strategy; Qualifications included in job description above	Workplan on CHW workforce strategy; Qualifications included in job description above	Project
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	Workplan showing timelines; Policies and Procedures; Training dates and materials	Project
		PPS has developed plans to develop operational program components of CHW.	Workplan addresses deployment of the CHWs.	Workplan addresses deployment of the CHWs.	Project

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

Definition of Actively Engaged	The number of expecting mothers and mothers participating in this program.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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.	Documentation of agreements with MCOs.	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Definition of Actively Engaged	The number of participating patients receiving palliative care procedures at participating sites, as determined by the adopted clinical guidelines.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	Roster of participating NCQA PCMH certified PCPs and/or PCPs meeting APCM requirements; PCP agreements committing to integrate Palliative Care; Agreements with non-PCMH certified and/or APCM approved PCPs committing to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM model	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	Provider (PCP)
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	Agreements between the PPS and community and provider resources including Hospice	Project
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; Agreements from all partners**; Training dates, materials, and number of staff attending; Demonstrated use of the MOLST form, where appropriate	**Clinical Guidelines and agreements from all partners;** Training dates, materials, and number of staff attending; Demonstrated use of the MOLST form, where appropriate	Project

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

Definition of Actively Engaged	The number of participating patients receiving palliative care procedures at participating sites, as determined by the adopted clinical guidelines.

Project Requirement		Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
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	Written training materials; List of training dates along with number of staff trained	Project
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	Written agreements	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

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

Index Score = 25

Definition of Actively Engaged	The number of participating patients receiving palliative care procedures at participating sites as determined by the adopted clinical guidelines.

	Project Requirement	Metric/Deliverable	Data Source(s)	Old Data Source(s)	Unit Level
1	Integrate Palliative Care into practice model of participating Nursing Homes.	PPS has integrated palliative care into Nursing Homes in alignment with project requirements.	Agreements with SNFs committing to integrate Palliative Care into the practice model; **Quarterly report narrative demonstrating successful implementation of project requirements**	Agreements with SNFs committing to integrate Palliative Care into the practice model; **Quarterly reports demonstrating successful implementation of project requirements**	Provider (SNF, Hospice)
2	Contract or 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 nursing home.	Agreements between the PPS and community and provider resources including Hospice	Agreements between the PPS and community and provider resources including Hospice	Project
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; Agreements from all partners;** Demonstrated use of the MOLST form, where appropriate	**Clinical Guidelines and agreements from all partners;** Demonstrated use of the MOLST form, where appropriate	Project
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	Written training materials; List of training dates along with number of staff trained	Project
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	Written agreements	Project
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)	Sample data collection and tracking system; EHR completeness reports (necessary data fields are populated in order to track project implementation and progress)	Project

Timeframe previously: Project System Changes

Changed from: The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP