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

DSRIP Implementation Plan Project

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

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Quarterly Report - Implementation Plan for Advocate Community Providers, Inc.

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

Status By Section

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

Status By Project

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

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget Report (Baseline)

Instructions :

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

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	53,823,271	57,357,917	92,754,950	82,134,154	53,823,271	339,893,561
Cost of Project Implementation & Administration	**16,146,981**	**17,207,375**	**27,826,485**	**24,640,246**	**16,146,981**	**101,968,068**
Implementation	12,917,269	13,249,679	20,313,334	16,262,562	10,011,128	72,753,972
Administration	3,229,712	3,957,696	7,513,151	8,377,684	6,135,853	29,214,096
Revenue Loss	**6,458,793**	**6,882,950**	**11,130,594**	**9,856,098**	**6,458,793**	**40,787,228**
Internal PPS Provider Bonus Payments	**20,452,843**	**21,796,008**	**35,246,881**	**31,210,979**	**20,452,843**	**129,159,554**
Cost of non-covered services	**2,691,164**	**2,867,896**	**4,637,748**	**4,106,708**	**2,691,164**	**16,994,680**
Other	**8,073,491**	**8,603,688**	**13,913,243**	**12,320,123**	**8,073,490**	**50,984,035**
Contingency Fund	5,382,327	5,735,792	9,275,495	8,213,415	5,382,327	33,989,356
Other	2,691,164	2,867,896	4,637,748	4,106,708	2,691,163	16,994,679
Total Expenditures	**53,823,272**	**57,357,917**	**92,754,951**	**82,134,154**	**53,823,271**	**339,893,565**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 1.2 - PPS Budget Report (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
53,823,271	339,893,561	35,849,124	321,919,414

Budget Items	DY1 Q3 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**9,470,685**	**9,470,685**	**6,676,296**	**41.35%**	**92,497,383**	**90.71%**
Implementation	7,439,291					
Administration	2,031,394					
Revenue Loss	**0**	**0**	**6,458,793**	**100.00%**	**40,787,228**	**100.00%**
Internal PPS Provider Bonus Payments	**6,785,429**	**8,503,462**	**11,949,381**	**58.42%**	**120,656,092**	**93.42%**
Cost of non-covered services	**0**	**0**	**2,691,164**	**100.00%**	**16,994,680**	**100.00%**
Other	**0**	**0**	**8,073,491**	**100.00%**	**50,984,035**	**100.00%**
Contingency Fund	0					
Other	0					
Total Expenditures	**16,256,114**	**17,974,147**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.3 - PPS Flow of Funds (Baseline)

Instructions :

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

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

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	53,823,271	57,357,916	92,754,950	82,134,154	53,823,271	339,893,561
Practitioner - Primary Care Provider (PCP)	11,841,119	12,618,742	20,406,089	18,069,514	11,841,120	74,776,584
Practitioner - Non-Primary Care Provider (PCP)	2,691,164	2,867,896	4,637,746	4,106,708	2,691,164	16,994,678
Hospital	7,363,001	7,846,539	12,688,838	11,235,918	7,363,001	46,497,297
Clinic	285,030	303,749	491,200	434,955	285,030	1,799,964
Case Management / Health Home	663,996	707,601	1,144,279	1,013,256	663,996	4,193,128
Mental Health	932,736	993,990	1,607,407	1,423,353	932,736	5,890,222
Substance Abuse	932,736	993,990	1,607,407	1,423,353	932,736	5,890,222
Nursing Home	526,731	561,323	907,729	803,791	526,731	3,326,305
Pharmacy	251,955	268,501	434,199	384,481	251,955	1,591,091
Hospice	187,457	199,767	323,049	286,059	187,457	1,183,789
Community Based Organizations	447,267	476,639	770,789	682,528	447,267	2,824,490
All Other	27,700,079	29,519,180	47,736,218	42,270,238	27,700,078	174,925,793
PPS PMO	0	0	0	0	0	0
Total Funds Distributed	**53,823,271**	**57,357,917**	**92,754,950**	**82,134,154**	**53,823,271**	**339,893,563**
Undistributed Revenue	**0**	**0**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 1.4 - PPS Flow of Funds (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
53,823,271	339,893,561	47,037,842	333,108,132

Funds Flow Items	DY1 Q3 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project										DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS											
			2.a.i	2.a.iii	2.b.iii	2.b.iv	3.a.i	3.b.i	3.c.i	3.d.iii	4.b.i	4.b.ii		
Practitioner - Primary Care Provider (PCP)	1,560,452	3,107,747	12	10	4	4	15	15	10	10	10	10	8,733,372	71,668,837
Practitioner - Non-Primary Care Provider (PCP)	75,365	246,103	5	15	2	10	15	15	15	15	4	4	2,445,061	16,748,575
Hospital	3,431,579	3,431,579	5	5	36	30	5	5	5	5	2	2	3,931,422	43,065,718
Clinic	0	0	0	0	0	0	0	0	0	0	0	0	285,030	1,799,964
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0	0	663,996	4,193,128
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	932,736	5,890,222
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	932,736	5,890,222
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	526,731	3,326,305
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	251,955	1,591,091
Hospice	0	0	0	0	0	0	0	0	0	0	0	0	187,457	1,183,789
Community Based Organizations	0	0	0	0	0	0	0	0	0	0	0	0	447,267	2,824,490
All Other	0	0	0	0	0	0	0	0	0	0	0	0	27,700,079	174,925,793
PPS PMO	0	0											0	0
Total Funds Distributed	**5,067,396**	**6,785,429**												

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

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

Funds flow dollars are actual YTD end 12/31/2015.

Rationale for percent distribution amongst projects is as follows:
PCP: Project expenses and effort primary resides with IDS, Health Home At Risk and Domain 3 and 4 Projects as these are projects that Primary Care face on a daily basis. The event-based projects of ED and Transition of Care resides primarily with Hospital provider types, but PCP effort is still impacted based on the appointment follow up requirements.

Non-PCP: Relatively lower IDS and Domain 4 Project expenses and effort, as these are primarily PCP functions. Higher effort with Health Home at Risk and Domain 3 Projects are Non-PCPs are a cornerstone in referral patterns specific to the Projects. Similar logic of importance of Non-PCPs in referral patterns also apply to Transition of Care Project (post-discharge may lead to more frequent referrals). Minimal ED effort due to non-involvement with direct appointment follow up requirements, however may still be part of referral pattern.

Hospital: Relatively higher rates of expense and effort for the two event-based ED and Transition of Care Projects. Relatively lower rates of effort for IDS, Health Home at Risk, Domain 3 and 4 projects since these are primarily outpatient office-based Projects.

Module Review Status

Review Status	IA Formal Comments
Pass (with Exception) & Ongoing	The amounts and percentages reported in the Provider Import/Export Tool does not align with the amounts and percentages reported in MAPP. Please update all amounts and percentages to ensure alignment and accuracy during the DY1, Q4 reporting period.

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IPQR Module 1.5 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Completed	Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Milestone Review Status

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

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IPQR Module 1.6 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.7 - IA Monitoring

Instructions :

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Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1 ACP Board Structure	Completed	1 Complete ACP Board Structure	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2 ACP Committee Structure	Completed	2 Complete ACP Committee Structure	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3 ACP Board of Directors	Completed	3 Select and confirm ACP Board of Directors	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 4 ACP Officers	Completed	4 Appoint ACP Officers	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 5 Approve Bylaws	Completed	5 Approve Bylaws	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 6 Steering Committee	Completed	6 Establish Steering Committee	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 7 Committee Chairs/Co-Chairs	Completed	7 Select Committee Chairs/Co-Chairs	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 8 ACP Subcommittees	Completed	8 Finalize ACP subcommittees and membership	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 9 Meeting Schedules	Completed	9 Establish Board and Committee Meeting Schedules	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 10 Operational Locations	Completed	10 Determine ACP operational locations	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 1 Appoint CMO	Completed	1 Appoint Chief Medical Officer, Jackson Kuan, MD	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2 Clinical Quality Committees	Completed	2 Establish clinical quality committees for each project	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3 Evidence-Based Protocols	Completed	3 Establish and distribute evidence-based clinical protocols and processes	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 4 Procedure Manual	Completed	4 Create and distribute process and procedure manuals for compliance	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5 Physician Engagement Teams	Completed	5 Establish physician engagement teams to monitor adherence to protocols and workflow processes. The physician engagement teams include members from the communities in which the physicians serve. They are culturally and linguistically competent therefore understand the culture of the communities and can provide assistance and support to the physicians in the implementation of the projects in a way that is most efficient.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6 Performance Reporting Metrics	Completed	6 Create and adopt Performance reporting Metrics. These performance metrics are developed from industry and evidence based monitoring standards which reveal not only when a patient is engaged, but also the timeliness and effectiveness of the interventions. These metrics include such values a, Hgb a1c levels to demonstrate effectiveness of hypoglycemic therapy, Monitoring BP levels, Flow sheets demonstrating episodic treatments and exacerbations, Rates of hospital utilizations and trending of these values to show progression or control and enhanced performance and outcome.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7 PAC and Care Team Roles	Completed	7 Confirm PAC and Care Team members and establish defined roles for each. The PAC serves in ACP as a true advisory committee, reviewing processes and protocols and providing ACP's Project Management Office with input on efficacy of same. ACP's PAC represents and communicates the voice of its over 200 partners. The PAC is made up of ACP partners from all different provider types and they are part of the ACP Care Teams which they then serve to represent before the PMO. They bring the voice of the	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		partners as well as the feedback on processes, which they also assist in creating. The Care Teams are regional and are made up of all ACP partners of all provider types within a geographical area. The Care Teams are the "ground troops" of ACP. They are the partners committed to providing care to ACP's patients in accordance with the ACP established protocols and processes.							
Task 8 Meeting Schedules	Completed	8 Establish committee meeting schedules	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1 Approve bylaws	Completed	1 Board of Directors will approve bylaws which shall be adopted immediately	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2 Appoint Compliance Officer	Completed	2 Appoint Compliance Officer and Communicate Compliance Policies and Procedures	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3 Adopt Key Corporate Compliance Policies	Completed	3 Compliance Officer and committee will develop and Adopt Key Corporate Policies and Procedures including but not limited to: Code of ethics, Conflict of interest, compliance, document destruction and Retention, HR policies and procedures, HIPAA, whistleblower policy.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 4 Dispute Resolution Policies	Completed	4 Board, compliance officer, and in-house attorney will draft and Adopt Dispute Resolution Policies and Procedures. If there is a conflict among partners, stakeholders or within any committees, the Board will make a determination after considering the facts and feedback from such partners and stakeholders. Depending on the nature of the issue, the issue may be submitted to one of the functional committees (i.e., clinical, finance, HIT, audit, and compliance committees) if the issue falls within the scope of any such committee, or a special subcommittee of the Steering Committee or the PAC.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5 Provider Performance Policies	Completed	5 Board, compliance officer and in-house attorney shall draft and Adopt Underperforming Provider Policies and Procedures and include them in the Provider Contracts	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6 Committee Guidelines	Completed	6 Develop Committee guidelines for each committee	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #4 Establish governance structure reporting and monitoring processes	Completed	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1 Analytics Team	Completed	1 Create Analytics team for pulling metrics, creating reports and providing analysis to present to clinical management	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2 Clinical Quality Team Roles	Completed	2 Define roles of Clinical Quality Committee in monitoring and reporting	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3 Identify Performance Metrics	Completed	3 Identify and Select Key Metrics to Assess Achievement/Engagement performance. These metrics will include analysis of patients achieving target goals and those not, number of patients engaged using internal reporting codes pulled from EMR and practice management systems, measurement of avoidable hospital utilizations based on PPS developed algorithms that use predictive measures such as length of hospital stay/ICD/number of episodes, and others. Performance of the governing committees will also be measeured. These will be measured through committee meeting minute analysis, through review of committee reports on analyses done on reports received and reviewed. Results should be analyzed by the committees and reports provided to the PMO including General Project Manager and CMO, Reports from the committees whall be due periodically, sometimes monthly and sometimes quarterly depending on the committee and the data being analayzed. Some examples are the Clincial Quality Committee may receive and review reports on performance monthly, which it then mustanalyze and present findings to the PMO monthly. The Clinical Committee shall review and update evidence based protocols and processes at a minimum yearly which it will then present to the PMO for distribution to partners. All other committees and workgroups also have deliverables that will be measured consistently and evaluated for efficiency, accuracy and effectiveness.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4 Collecting and Reporting Data	Completed	4 Develop Tools for Collecting and Reporting Data from all Participating Providers and Communicating Results. These	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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DSRIP Implementation Plan Project

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		tools will include homegrown reporting codes that are posted at encounters, use of registries, MCO reports, laboratory test result values, amongst others.							
Task 5 Reporting Schedule	Completed	5 Establish reporting periodicity. The PPS foresees a monthly reporting schedule	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6 Reporting Baselines and Thresholds	Completed	6 Establish baselines and thresholds to measure provider performance and implement corrective action plan implementation needs	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 7 Corrective Action Plan	Completed	7 Develop a provider corrective action plans and penalty/reward system to be implemented by provider quality control and communications committee	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8 Reporting Workflows	Completed	8 Establish upstream information workflow processes (information from providers to PPS)	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 9 Oversight Authority	Completed	9 Determine oversight authority for implementation of corrective action	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Completed	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	NO
Task 1 Community Engagement	Completed	1 Establish community engagement unit/hire unit director and Manager of Community Health Worker Program.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2 Establish Communications Committee	Completed	2 Establish Communications committee and hire and engage a communications/public relations firm with experience in health care.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3 Messaging	Completed	3 Conduct messaging exercise	05/01/2015	07/31/2015	05/01/2015	07/31/2015	09/30/2015	DY1 Q2	
Task 4 Finalize Communications Plan	Completed	4 Finalize Communications Plan in accordance with DSRIP guidelines	05/01/2015	07/31/2015	05/01/2015	07/31/2015	09/30/2015	DY1 Q2	
Task 5 Communications Plan	Completed	5 Provide draft of community engagement plan. The plan includes the following components: definition of the role that neighborhood based medical practices will play within the overall community engagement plan; plan to conduct outreach to patients within the community that may not be in contact with primary care physicians; Identification of major/local engagement events to include engagement	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		through educational activities such as health fairs and Stanford Model educational meetings/seminars, amongst others; plans for media outreach (including local and ethnic Media); schedule of outreach efforts to key elected and appointed officials; CBO outreach and engagement plan and schedule; public and non-provider organizations engagement plan; Outreach to community and school boards and local health department offices; and Recruitment, training and deployment of CHWs as a major component of the overall plan to engage the community. This engagement will insure our ability to reach patients in their own culture and neighborhood, increase health literacy, and allow patients access to more efficient care and preventative services.							
Task 6 Finalize Schedule	Completed	6 Finalize monthly schedule of engagement activities/events	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7 Steering Committee Review	Completed	7 Submit final draft of the community engagement plan to Steering Committee for input and governance board for review and approval.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #6 Finalize partnership agreements or contracts with CBOs	Completed	Signed CBO partnership agreements or contracts.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task 1 Establish CBO Proposal	Completed	1 Working closely with partners and selected leaders of major CBOs, ACP staff under the division of Workforce, Community and Government Relations will develop a "Proposal to Establish the CBO Partnership Program" (CBOPP) for collaborating on outreach and organizing, patient engagement and education, community health workers, and cultural competence and health literacy training. Once proposal is approved by Senior Management, staff initiates implementation.	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2 Expression of Interest Request	Completed	2 The partnership development process begins with the issuance of A request for An Expression of Interest (EI). The request for an EI is circulated amongst key CBOs throughout the target area on an invitational basis. A number of factors will be utilized to determine which CBOs will be invited to submit responses to the EI request. These may include:	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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		Affinity with ACP's goals and objectives; population health needs and capacity to provide needed services; CBOs whose major area of operations is within a "Hotspot;" relationship of the CBO to the community; experience of the CBO in the engagement and deployment of CHWs; cultural competence; and service offerings compatible with ACP needs and interests. Prior to the release of the solicitation, staff submits the proposed EI to the Compliance Officer and legal counsel for review and approval.							
Task 3 Review EI Responses	Completed	3 ACP staff reviews responses to the EI and works with the pre-selected CBOs to draft contractual agreements delineating areas of collaboration. An Ad Hoc Committee composed of Board and Steering Committee members is created to review and finalize agreements with CBOs based on staff recommendations. The agreements clearly define project objectives and a plan to monitor and evaluate activities and outcomes.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4 Execute Agreement and Training	Completed	4 Contractual agreements with CBOs are executed and staff provide training, oversight and guidance.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Completed	Agency Coordination Plan.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task 1 Identify Local Support Agencies	Completed	1 Through the CNA process ACP identified several agencies including local neighborhood, state and city that can afford services to its patients to better help in the implementation of treatment plans and to improve patient's health and health literacy. These agencies include the New York City department of health and mental hygiene, NYC Department of Education, NY QUITS, and the NYC HRA among others. ACP also has relationships and partners that it is leveraging such as with Office of Mental Health, and organizations of people with disability such as Federation of Organizations for NYS Mentally Disabled Through its relationship with these	04/01/2015	07/31/2015	04/01/2015	07/31/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		and other agencies ACP will coordinate patient care and education . Some of these agencies represented on the PAC, Clinical Quality Committees as well as the Care Teams. ACP will Identify and select all pertinent state and local public sector agencies that will assist in providing services to ACP patients including housing, tobacco cessation, in school treatment plans, etc.							
Task 2 Develop an ACP Public Agency Coordination Plan	Completed	2 Establish division for Workforce, Community and Government Relations; appoint Division Director.	04/01/2015	07/31/2015	04/01/2015	07/31/2015	09/30/2015	DY1 Q2	
Task 3 CBO Liaison	Completed	3 Identify staff (liaison) responsible for coordinating with public sector agencies; coordinate plan development activities with the PAC.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4 Review ACP Public Agency Coordination Plan	Completed	4 Draft report identifying public sector agencies that will assist in providing services to ACP patients. The report will include information about the services to be provided, the roles and responsibilities of key public sector agencies within DSRIP.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5 Finalize ACP Public Agency Coordination Plan	Completed	5 Finalize plan to execute collaborative agreements with public sector agencies. Such agreements will include process and procedures for the exchange of information including patient specific information in accordance with HIPPA regulations, process and procedures for client referrals, opportunities for joint planning including involvement in Advisory Committees whenever possible, collaboration around domain 4 initiatives, opportunities for training around a wide range of issues including cultural competency and health literacy, involvement in joint community engagement activities and events, and participation in public/community events.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6 Submit Agency Coordination Plan	Completed	6 Submit agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels to Steering Committee for input and governing board for review and approval.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #8 Finalize workforce communication and engagement plan	Completed	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		(e.g. workforce transformation committee).							
Task 1 Workforce Communication and Engagement Strategy	Completed	1 Establish a working group of the Workforce Committee to develop a comprehensive Workforce Communication and Engagement Strategy based on PPS Communication Plan; subcommittee includes labor representatives.	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2 Workforce Communication and Engagement Plan	Completed	2 The subcommittee finalizes a draft of the Workforce Communication and Engagement Plan; the plan will: include strategies for communications about job requirements, training opportunities, and advancement opportunities to all pertinent staff; strategies for partners to communicate changes in the workforce at the partner level-training and retraining needs as well as new hires to Workforce Department for consistency in reporting, training and staff development; utilize a broad range of media from print to the internet and the ACP website, to text and emails as well as the media at large; the plan will communicate information regarding ACP, DSRIP, job training and growth opportunities, employment availability postings and other job and employment related issues; the plan will be interactive and include opportunities for two-way communication with the workforce.	10/01/2015	10/31/2015	10/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task 3 Workforce Review	Completed	3 The plan is presented to and reviewed by selected members of the workforce for additional input.	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4 Final Approval	Completed	4 Final draft of the plan is presented to the Steering Committee and the PPS Governance Board for final approval.	12/01/2015	12/31/2015	12/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5 Review and Approve Communication Plan	Completed	5 Communication plan is reviewed and approved by Governing Board	12/01/2015	12/31/2015	12/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #9 Inclusion of CBOs in PPS Implementation.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	07/01/2015	06/30/2017	07/01/2015	06/30/2017	06/30/2017	DY3 Q1	NO
Task 1 Identify CBOs	Completed	1 Identify CBOs in network, determine gaps in network (service-level and geographic level), determine capabilities for integration and review/execute PPS agreements with CBOs. Network CBOs, such as God's Love We Deliver, a meals	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		delivery organization; Catholic Charities which has several branches providing housing and social services; local YM/WHA, which provides services to seniors and children; NY QUITS; City Department of health and mental hygiene; Department of Education and many others will be part of the milestone. However, there are still others that ACP will be reaching out to further increase its reach to ACP's vast network of patients, providers and geographical area.							
Task 2 Establish Roles	In Progress	2 Establish roles for each CBO. CBOs provide a wide variety of services. Important to convey expected roles for each so that PPS service delivery is comprehensive.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3 System Integration	In Progress	3 Based on capabilities, establish plan to integrate CBOs. Ideal state is CBO has robust system that can fully integrate with PPS HIE and/or care management system. If system will not be compatible for integration (ie paper, limited technology), workflows will be developed to ensure effective communication with feedback loop are present. Adequate support will be evaluated at the individual CBO level.	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1	

IA Instructions / Quarterly Update

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

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Establish governance structure reporting and monitoring processes	jd593813	Policies/Procedures	25_MDL0203_1_3_20160316000148_Gov_4_-_Governance_Reporting_and_Monitoring_Process.docx	Remediation response to Governance Milestone 4 - Reporting and monitoring process	03/16/2016 12:01 AM
	jd593813	Policies/Procedures	25_MDL0203_1_3_20160131174729_Financial_Su	File titled 'Financial Sustainability 3.4 CAP' also	01/31/2016 05:47 PM

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
			stainability_3.4_CAP.pdf	applies to Governance 4.7.	
Finalize partnership agreements or contracts with CBOs	jd593813	Contracts and Agreements	25_MDL0203_1_3_20160131175202_Governance_6.4_CBO_MOU_Various.pdf	CBO Memorandum of Understanding for various CBOs	01/31/2016 05:52 PM
	jd593813	Contracts and Agreements	25_MDL0203_1_3_20160131175119_Governance_6.4_CBO_MOU_Get_Focused.pdf	CBO Memorandum of Understanding/Agreement	01/31/2016 05:51 PM
	jd593813	Other	25_MDL0203_1_3_20160131175038_Governance_6.3_CBO_Review.pdf	CBO Review	01/31/2016 05:50 PM
	jd593813	Communication Documentation	25_MDL0203_1_3_20160131175001_Governance_6.2_CBO_RFI.pdf	CBO Request for Information	01/31/2016 05:50 PM
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	jd593813	Other	25_MDL0203_1_3_20160131175405_Governance_7.4-7.6_Public_Agency_Coordination_Plan.pdf	Public Agency Coordination Plan	01/31/2016 05:54 PM
Finalize workforce communication and engagement plan	jd593813	Templates	25_MDL0203_1_3_20160316104715_Gov_8_Communications_Committee_Meeting_Schedule.xlsx	Remediation response to Governance Milestone 8 - meeting schedule template attached.	03/16/2016 10:47 AM
	jd593813	Other	25_MDL0203_1_3_20160315223642_Gov_8_Communication_Committee's_Charter.docx	Remediation response to Governance Milestone 8 - documentation that states meetings are held 'quarterly' as well as the primary goals and objectives of the Communication Committee.	03/15/2016 10:36 PM
	jd593813	Templates	25_MDL0203_1_3_20160315223334_Gov_8_Workforce_Communications_Committee_Members.xlsx	Remediation response to Governance Milestone 8 - Workforce Committee Member template attached.	03/15/2016 10:33 PM
	jd593813	Other	25_MDL0203_1_3_20160131181225_Governance_8.2-8.5_Workforce_Comm_and_Engagement_Strategy.pdf	Workforce Communication and Engagement Strategy	01/31/2016 06:12 PM
Inclusion of CBOs in PPS Implementation.	jd593813	Other	25_MDL0203_1_3_20160131181602_Governance_9.1_CBO_and_BH_Providers_List_2015_01_21.xlsx	CBO and BH Providers List	01/31/2016 06:16 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	
Finalize bylaws and policies or Committee Guidelines where applicable	
Establish governance structure reporting and monitoring processes	
Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	
Finalize partnership agreements or contracts with CBOs	Remediation instructions mentioned to keep status as 'In Progress', however we are unable to attest with the status as 'In Progress' and had to change to 'Submitted'.
Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Remediation instructions mentioned to keep status as 'In Progress', however we are unable to attest with the status as 'In Progress' and had to change to 'Submitted'.
Finalize workforce communication and engagement plan	
Inclusion of CBOs in PPS Implementation.	

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Complete	
Milestone #2	Pass & Complete	
Milestone #3	Pass & Complete	
Milestone #4	Pass & Complete	
Milestone #5	Pass & Complete	
Milestone #6	Pass & Ongoing	The IA has accepted the narrative indicating the intent of the PPS to have this milestone changed to "In process". In DY1Q4 please change your milestone Status to "In process" and update the milestone end date to align with the intent of your narrative submission.
Milestone #7	Pass & Ongoing	The IA has accepted the narrative indicating the intent of the PPS to have this milestone changed to "In process". In DY1Q4 please change your milestone Status to "In process" and update the milestone end date to align with the intent of your narrative submission.

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #8	Pass & Complete	
Milestone #9	Pass & Ongoing	

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IPQR Module 2.2 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1 Inclusion of CBOs	In Progress	Working with existing CBO network partners (such as RAIN, East Harlem HELP, God's Love We Deliver, Samaritan Village, Narco Freedom, Catholic Charities, YM/WHA) and selected leaders of major CBOs (such as the Hispanic Federation, the Federation of Protestant and Welfare Agencies, The NY Immigration Coalition, the Association of Black Executive Directors and others) ACP staff under the division of Workforce, Community and Government Relations will develop a "Proposal to Establish the CBO Partnership Program" (CBOPP). CBOPP was designed in order to insure that CBOs play an important role in the development of ACP. The CBOPP program will carve out roles for CBOs within ACP to include but not be limited to: • Service delivery; • Outreach and organizing; • Patient engagement and education; • Deployment of community health workers; • Cultural competence and health literacy training; • Community organizing and mobilization Once solicitation instruments are approved by Senior Management, staff initiate implementation activities. A request for An Expression of Interest (EI) is circulated to key CBOs throughout the target area on an invitational basis. A sub-Committee of the Workforce Committee composed of Board and Steering Committee members is created to review and finalize	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
		agreements with CBOs based on staff recommendations. The agreements clearly define project objectives and a plan to monitor and evaluate activities and outcomes. Contractual agreements with CBOs are executed and staff provide oversight, training and guidance. ACP expects to contract with 10-20 CBOs with a special emphasis on "Hotspots" by DY1, Q4.						

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1 Inclusion of CBOs	

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

IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

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

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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IPQR Module 2.5 - Roles and Responsibilities

Instructions :

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

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

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Module 2.6 - IPQR Module 2.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 2.7 - IT Expectations

Instructions :

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

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

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

IPQR Module 2.8 - Progress Reporting

Instructions :

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

We look to create and adopt a dashboard with insightful data presented in an attractive format that informs and brings greater clarity to collective decision-making and reporting. While staff often track many metrics as part of a broader performance management system, Boards do not want to be overwhelmed with information. Therefore, the best governance dashboards use as few metrics as possible to communicate the organization's performance and progress against key initiatives. It can be as simple as indicating the targets and indicating whether or not ACP is meeting the targets. Nonprofit dashboards that use Green, Yellow and Red indicators demonstrate one simple way to let the board know if the organization is on track in terms of progress against key initiatives, including but not limited to, achieving the milestones laid out for ACP such as creating the governance structure, recruiting and filling the board and committee positions, developing and adopting bylaws, policies and procedures, contracting with CBOs and other key participants and others. The key is to get the board's attention on asking the right questions. The success of the board depends on its ability to make sound judgments in situations that involve balancing the competing interests of different stakeholders while delivering on key milestone results. Best practice governance embraces the 'CRAFTED' principles of governance: a culture and a climate of Consistency, Responsibility, Accountability, Fairness, Transparency, and Effectiveness that is deployed throughout the entire organization.

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Numerous governance rating models exist. We look to use or develop a model that not only looks at structural aspects of governance, such as the composition of the board and committees, but also aspects such as the decision-making process, the quality of information, and the results of oversight and guidance functions of the board of directors. ACP will build an organizational dashboard to standardize the tracking of ACP performance in terms of key measures of performance and outcomes. We will look to capture objectives, inputs, outputs, intermediate outcomes (benchmarks), final outcomes and performance indicators. The dashboard will show both current status (snapshot) and progress in terms of trends. Such reporting will include: attendees in meetings, meeting minutes, decision points suggested or made, and reporting to show approvals of outstanding committee or board meetings, etc. We will look to capture information to report on all of the work streams and projects. ACP has developed and is developing several reporting and monitoring metrics as well as clinical quality measures that will be used to monitor success of the clinical and related work streams. Appropriately engaging and systematically communicating with stakeholders is important to the successful design and implementation of the governance plan. The participation and acceptance of key stakeholder groups is crucial in developing a system that is supported by the larger community and likely to be sustained. Ongoing and targeted communication between project leaders and stakeholder groups is critical to ensure programmatic success. Implementing value-based, performance-pay and risk-based systems is a way of securing continued interest, buy-in and sustainability of transformation. Commitment to a new compensation system is essential to a program's success as well as its long-term sustainability.

IPQR Module 2.9 - IA Monitoring

Instructions :

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Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1 Identify Leadership	Completed	1 Identify and hire CFO	07/01/2015	07/31/2015	07/01/2015	07/31/2015	09/30/2015	DY1 Q2	
Task 2 Finance Charter	Completed	2 Define roles and responsibilities of Finance team (i.e. Charter), including reporting structure(completion of org chart).	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3 Staffing Needs	Completed	3 Define staffing needs, roles and responsibilities	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4 Hire Staff	Completed	4 Identify and hire Finance Directors and other support staff	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5 Finalize Fiduciary Agreement	Completed	5 Define duties of fiduciary (NSLIJ) including policies, structure and fees	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6 Finance Committee	Completed	6 Identify members of the Finance Committee	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7 Establish Policies and Procedures	Completed	7 Establish policies and procedures regarding: -Funds flow -Accounting (selection of software, system) -Budget process, including orders and requests	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8 Board Approval	Completed	8 Obtain Board approval for proposed Finance functions.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	In Progress	This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers							
Task 1 DSRIP Reporting Requirements	Completed	1 Determine reporting requirements as defined by DSRIP guidelines regarding financial sustainability	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2 Create Financial Sustainability Survey	Completed	2 Create Financial Sustainability Survey to assess current state of PPS providers	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3 Determine Criteria	Completed	3 Determine criteria of what defines financially fragile providers and create policies and procedures that include support of these providers	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4 Assess Impact	Completed	4 Assess impact of projects in terms of implementation costs (training, in-servicing, etc.) and business impacts (reduction of inpatient services).	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5 Develop Strategy	In Progress	5 Develop financial stability strategies for those at risk partners	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6 Hire Support Staff	Completed	6 Hire staff (financial analyst) dedicated to collecting and monitoring providers and financial stability measures	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7 Complete Assessment	Completed	7 Complete assessment (analyze results, identify providers at risk, identify providers who are recipients of the IAAF). Determine next steps with at-risk providers including understanding of drivers of financial instability and assistance with revenue stream improvement. Propose potential PPS support including: - Centralized resource support - Training for additional billable services - Support for value-based services - Allocation of funds flow dollars	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8 Develop Schedule	In Progress	8 Develop an annual schedule to monitor financial sustainability of providers (more frequently if provider is considered financially fragile)	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task	In Progress	9 8 Obtain Board approval for proposed Financial	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
9 Board Approval		Sustainability strategy							
Task 9 Continue Monitoring	In Progress	9 Continue with sustainability monitoring based on annual schedule, for financially fragile providers	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1 Draft Compliance Plan	Completed	1 Identify and retain proper counsel to draft compliance plan consistent with 363-d, including written policies and procedures that includes all required elements (code of conduct, training and education program, communication lines to Compliance Officer (Tom Hoering), disciplinary procedures, [routine] system of identifying risks and areas of non compliance, system to respond to identified issues, policy of non-retaliation) and applicable departments and workstreams. Ensure compliance program certification requirements are in place.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2 Approve Plan	Completed	2 Approve plan and execute on deliverables required by such plan	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3 Reporting Needs	Completed	3 Engage IT to configure system that meets compliance plan's reporting needs	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4 Plan for Non-Compliance	Completed	4 Develop process that addresses providers who do not meet compliance requirements, including Corrective Action Plans that will assist with meeting compliance.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5 Compliance Officer	Completed	5 Appoint Compliance Officer	04/01/2015	04/30/2015	04/01/2015	04/30/2015	06/30/2015	DY1 Q1	
Task 6 Compliance Meeting Schedule	Completed	6 Implement frequent meetings between Compliance Officer and Board to ensure plan is effective and maintained.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7 Training	Completed	7 Provide recurring training that satisfies requirements.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task 1 Leverage Existing Relationships w MCOs and Develop VBP Transition Plan	In Progress	1 Leverage PPS relationships with MCOs already in place for value based payments. Present, educate and align PPS	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		providers to value-based payment methodologies and partner with MCOs to develop value-based payment plans - Introduce value-based concept and perform a survey to engage providers, including performance tiering and establish expectations - Perform analysis of revenue as well as expense models (revenue: understand appropriate loss ratio targets based on Medicaid premium, potential admin and care management costs, and costs of other impacts such as workforce impact, and expense: expected expense thresholds in provider settings, expected expense targets for MCO's to determine revenue targets) - Establish detailed baseline based on current utilization and model outcomes - Establish roles and expectations for each participating provider - Monitor funds flow - Present transition timeline							
Task 2 Establish Data Feeds	In Progress	2 Establish appropriate and recurring data feeds from MCOs to monitor revenue and expense trends (cost and utilization). Establish value initiatives that improve or target highlighted trends.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3 Engage MCO for PPS Performance	In Progress	3 Engage with MCOs to identify (timely) PPS performance at all levels, engage partners to ensure that plan is satisfactory and considers concerns that are raised. Performance includes medical expense trends and care gaps, amongst others.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4 Reporting	In Progress	4 Create reporting from MCO data at appropriate detail levels (by provider, by region/county) for management review and distribution to providers	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 5 Performance Grading	In Progress	5 Develop methodology to 'grade' providers - establish guidelines for surplus sharing based on provider type. Conversely, establish mitigation plans if providers are in deficit.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 6 Provide Support	In Progress	6 Ensure adequate support for providers throughout entire process, including monthly meetings to discuss performance	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		and mitigation steps if performance is negative. Support includes: Provider Engagement Outreach Team, education and training, standard reporting definitions, etc.							
Task 7 Underperforming Provider Support	In Progress	7 Develop action plan to support providers unable to perform under value-based system. At this point, providers have been educated about VBP plan and transition timeline (see step 1), provided reports, expectations and actionable steps, and presented a support structure.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 8 Corrective Action Plans	In Progress	8 Establish corrective action plan for treatment of providers unable to improve performance	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 9 Board Approval	In Progress	9 Appropriate Board approval of all proposed policies and procedures.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	YES
Task 1 VBP Plan	In Progress	1 Develop VBP plan with input from MCO, providers, and key stakeholders and determine approach for PPS in its entirety (IPC vs bundles of care vs subpopulation risk) including ramp-up steps until Level III VBP is achieved. Plan includes milestones such as time frame for each value-based approach, ultimately achieving value-based payments that are 90% of total payments to providers. Plan includes: - Understanding of provider capabilities and knowledge of value based payments (FFS vs capitation with withholds vs upside and risk vs global cap arrangements) - Development of key performance indicators and reporting set that directly tie to value based reimbursement - Development of baseline for each provider/group and highlight actionable items to produce positive VBP, establish goals and targets for provider - Provide tools and support to assist providers with incorporating workflow improvements and efficiencies within each practice/provider setting (incorporate integrated delivery system tools within workflows, centralized care management,	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		etc) - Provide monthly/quarterly progress reports and actionable items aligned with goals and targets - transition timeline, cost/benefit analysis with each VBP level scenario							
Task 2 Engage MCOs	In Progress	2 Engage MCOs with VBP plan to gauge feasibility of plan implementation within MCO system, establish appropriate data feeds, and reporting requirements. Leverage MCO expertise and resources (actuarial, contracting, provider outreach) to assist with transition include metric development and communication with providers.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 3 Provider Engagement and Adoption	In Progress	3 Establish roll-out plan for provider engagement and adoption. Introduce plan to providers in PPS, specifying roles of all provider types and those considered safety-net vs non-safety net.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 4 Establish Reporting Set	In Progress	4 Develop robust reporting set so providers can monitor their performance at all levels (provider, group, county, etc.) and develop actionable items to positively impact trends, where necessary. Also develop plan to assist providers who are in 'deficit' or where performance doesn't allow for value-based payments.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 5 Board Approval	In Progress	5 Finalize and acquire Board approval for VBP plan for PPS. Plan to include scope, provider type at risk, expectations, metrics required and reporting requirements.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
to be in Level 2 VBPs or higher									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize PPS finance structure, including reporting structure	jd593813	Templates	25_MDL0303_1_3_20160315224852_Meeting_Template_-_Financial_Stability.xlsx	Remediation response to Financial Stability Milestone 1 - Finance Committee meeting template attached.	03/15/2016 10:48 PM
	jd593813	Policies/Procedures	25_MDL0303_1_3_20160131172555_Financial_Sustainability_1.7_Finance_Funds_Flow_Reporting_Policies_and_Procedures.pdf	Finance and Funds Flow Policies and Procedures	01/31/2016 05:25 PM
	jd593813	Policies/Procedures	25_MDL0303_1_3_20160131172516_Financial_Sustainability_1.7_Budget_Policies_and_Procedures.pdf	Budget Policies and Procedures	01/31/2016 05:25 PM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	jd593813	Documentation/Certification	25_MDL0303_1_3_20160315225527_Financial_Stability_3_OMIG_Certificate.pdf	Remediation response to Financial Stability Milestone 3 - OMIG Certification attached.	03/15/2016 10:55 PM
	jd593813	Other	25_MDL0303_1_3_20160131173602_Financial_Sustainability_3.6_Board_Meeting_Calendar.pdf	Board meeting schedule	01/31/2016 05:36 PM
	jd593813	Policies/Procedures	25_MDL0303_1_3_20160131173518_Financial_Sustainability_3.4_CAP.pdf	Corrective Action Plan - Pg 22 of document	01/31/2016 05:35 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	1.8 Board approval previously made to fiduciary agreement with Northwell.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	2.6 Staff hired - CFO, Deputy CFO and Bookkeeper/Analyst. Hiring will continue to be ongoing as needs arise. 2.7 Survey distributed with preliminary results. Survey administration is ongoing with annual re-assessments.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	1.6 Board schedule attached. Compliance update is a regular agenda item. 1.7 Compliance policy is to train PPS associates (which includes network physicians and providers).
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

Milestone Review Status

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

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IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

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

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

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

IPQR Module 3.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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IPQR Module 3.5 - Roles and Responsibilities

Instructions :

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

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

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IPQR Module 3.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 3.7 - IT Expectations

Instructions :

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

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

IPQR Module 3.8 - Progress Reporting

Instructions :

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

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

IPQR Module 3.9 - IA Monitoring

Instructions :

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Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1 Convene Advisory Group/Committee	Completed	1 Form a Cultural Competency and Health Literacy Advisory Committee of practitioners, advocates and SMEs to provide assistance and recommendations on the implementation of the cultural competency and health literacy strategy.	08/01/2015	08/30/2015	08/01/2015	08/30/2015	09/30/2015	DY1 Q2	
Task 2 Identify Target Areas ('Hotspots')	Completed	2 Identify and map the "hotspots" in the service area as it pertains to health disparities. The following methodology will be utilized to conduct the assessment: Review of DSRIP Program data on Health Data NY and other publicly available documents, including studies conducted by research institutes and advocacy groups in the field.	08/01/2015	08/30/2015	08/01/2015	08/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 3 Identify CBOs and Key Partners	Completed	3 Identify key CBOs and partner organizations that can deploy resources within the PPS to increase cultural competency and health literacy.	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4 Understand Best Practices Regarding Patient Outcomes	Completed	4 Complete compilation of best practices and methodologies for improving patient's health outcomes as it pertains to cultural competency and health literacy.	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5 Resource Inventory	Completed	5 Establish comprehensive inventory of all resources that can be deployed and accessed to increase cultural competency and health literacy across the network.	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6 Educational Campaign	Completed	6 Launch fact-finding campaign to gauge the needs of the PPS on issues related to cultural competency and health literacy. Meetings to be held with key physicians and stakeholder organizations coordinated through clinical care teams and the PAC Leadership Council.	09/01/2015	10/31/2015	09/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task 7 Financial Impact Report	Completed	7 Complete report on determining the costs associated with developing formal partnership agreements with other entities to help support the work of the PPS.	10/01/2015	10/31/2015	10/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task 8 Complete Final Draft	Completed	8 Complete final draft of the comprehensive cultural competency/health literacy strategy, including descriptions of the instruments, processes and procedures for monitoring and evaluating feedback and outcomes across the four major sectors of the PPS. The strategy will also include recommendations for assigning the implementation plan to the ACP Management Team with guidelines as to expected phase-in and completion dates. The assigned management team will be required to prepare quarterly reports on the progress of the plan to the Steering Committee and the Board.	10/15/2015	11/30/2015	10/15/2015	11/30/2015	12/31/2015	DY1 Q3	
Task 9 Present/Approve Final Draft	Completed	9 Present final draft of the comprehensive cultural competency/health literacy strategy for review and input to the Steering Committee. The Steering Committee submits the final document to the governance body for approval.	12/01/2015	12/31/2015	12/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate	In Progress	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-	08/01/2015	06/30/2016	08/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
material).		based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches							
Task 1 Convene Advisory Group/Committee	Completed	1 Convene Cultural Competency and Health Literacy Advisory Committee to provide input on the training strategy.	10/01/2015	10/31/2015	10/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task 2 Identify Groups Experiencing Health Disparities	Completed	2 Conduct Health Literacy Environment Review Survey to assess cultural competency levels, efforts to improve health literacy and training needs throughout the PPS.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3 Review Survey	In Progress	3 Work with SMEs to review survey results and evaluate training approaches.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 4 Draft Training Strategy	In Progress	4 Draft preliminary training strategy based on data gathered; formulate desired outcomes and evaluation criteria (i.e. performance metrics) based on assessment of training needs.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 5 Training Strategy	In Progress	5 Submit final draft of training strategy to the Steering Committee for review and input. The Steering Committee submits the final strategy document to the PPS Board of Directors for review and approval.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 6 Implementation	In Progress	6 Commence process of incorporating training into PPS workflow: build guiding coalition of PPS members, select target audiences, identify training vendors, establish training modes and locations, and determine length of training sessions.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy	jd593813	Meeting Materials	25_MDL0403_1_3_20160316111911_CC-	Remediation response to Cultural Competency	03/16/2016 11:19 AM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
strategy.			HL_Milestone_1_-_Board_Info.pdf	Health Literacy Milestone 1 - Board Info.	
	jd593813	Other	25_MDL0403_1_3_20160315230059_CC-HL_Milestone_1_-_Priority_Groups.docx	Remediation response to Cultural Competency Health Literacy Milestone 1 - Priority groups with health disparaties defined in the attached.	03/15/2016 11:00 PM
	jd593813	Other	25_MDL0403_1_3_20160202173645_CC-HL_1.7_Financial_Estimates.pdf	CBO Financial Estimates	02/02/2016 05:36 PM
	jd593813	Other	25_MDL0403_1_3_20160202173607_CC-HL_1.6_Focus_Group_Meeting_Summary.pdf	Focus Group Meeting Summary	02/02/2016 05:36 PM
	jd593813	Other	25_MDL0403_1_3_20160202173535_CC-HL_1.6_Focus_Group_Invite.pdf	Focus Group Invite	02/02/2016 05:35 PM
	jd593813	Other	25_MDL0403_1_3_20160131174033_CC-HL_1.8-1.9_CC-HL_Strategy.pdf	Cultural Competency Health Literacy Strategy Plan	01/31/2016 05:40 PM
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	jd593813	Other	25_MDL0403_1_3_20160202175524_CC-HL_2.2_Pilot_Analysis_Results_-_Dr_A_Comas.pdf	Pilot Assessment Results	02/02/2016 05:55 PM
	jd593813	Other	25_MDL0403_1_3_20160202175332_CC-HL_2.2_Health_Literacy_Scoring.pdf	Health Literacy Scoring Matrix	02/02/2016 05:53 PM
	jd593813	Other	25_MDL0403_1_3_20160202174438_CC-HL_2.2_Health_Literacy_Assessment_Tool.pdf	Health Literacy Assessment Tool	02/02/2016 05:44 PM
	jd593813	Other	25_MDL0403_1_3_20160202173957_CC-HL_2.2_Health_Literacy_Assessment_Memo.pdf	Health Literacy Assessment	02/02/2016 05:39 PM
	jd593813	Meeting Materials	25_MDL0403_1_3_20160202173928_CC-HL_2.1_Meeting_Minutes.pdf	Meeting Minutes	02/02/2016 05:39 PM
	jd593813	Meeting Materials	25_MDL0403_1_3_20160202173902_CC-HL_2.1_Committee_Meeting_and_Agenda.pdf	Committee Meeting and Agenda	02/02/2016 05:39 PM

Prescribed Milestones Narrative Text

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Fail	The documentation submitted was insufficient to demonstrate completion of the milestone. The PPS failed to submit documentation that the Cultural Competency & Health Literacy Strategy was approved by the Board. Failure to meet this milestone in DY1 Q3 will impact your payment in DY1 Q4. If you wish to appeal, you must do so within 5 business days. DY1 Q3 appeals will not be considered in subsequent periods.
Milestone #2	Pass & Ongoing	

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IPQR Module 4.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

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

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

IPQR Module 4.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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IPQR Module 4.5 - Roles and Responsibilities

Instructions :

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

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

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IPQR Module 4.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 4.7 - IT Expectations

Instructions :

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

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

IPQR Module 4.8 - Progress Reporting

Instructions :

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

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

IPQR Module 4.9 - IA Monitoring

Instructions :

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Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1 Establish Governance Structure	Completed	1 Establish IT Governance Structure: identify Director of IT, workstream structure and HIT committee.	07/01/2015	08/30/2015	07/01/2015	08/30/2015	09/30/2015	DY1 Q2	
Task 2 Readiness Assessment	Completed	2 Conduct IT readiness assessment and analyze results - assessment to include readiness of data sharing at provider level, and mapping of the various systems in use throughout the PPS network and their potential interoperability including QE/HIE/RHIOs. Assessment results to be tracked and maintained for each partner within the PPS and gaps addressed to ensure full functionality of an interoperable platform.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3 Creation of Work Plan	In Progress	3 Data from assessments will drive work plan. Plan expected to include: - Aggregate data to prioritize gaps - Establish workgroups to close gaps (expected gaps include: paper medical records, non-certified EHRs, data-sharing/connectivity barriers, workforce and other resource gaps, provider stakeholder buy-in, required technical support, etc) - Assess budgetary requirements for workgroups - develop	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		timeline based on resource need - Acquire necessary approvals (board, committee) - Deploy workgroups to close gaps - Provide periodic progress reports - if necessary, develop contingency plans to address new issues							
Task 4 Final Report	In Progress	4 Develop final report, including work plan to close gaps and impact to implementation of an interoperable IT platform, and present to leadership/Board.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 5 Share/Review Results	In Progress	5 Share results of IT readiness assessment and work plan with network partners and discuss implications at Provider IT workgroups and committee meetings.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 6 Workgroup Feedback	In Progress	6 Incorporate workgroup and committee suggestions into final plan regarding development of interoperable IT platform. Incorporate workgroup and committee suggestions into final plan.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 7 Board Approval	In Progress	7 Obtain Board approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop an IT Change Management Strategy.	In Progress	IT change management strategy, signed off by PPS Board. The strategy should include: -- Your approach to governance of the change process; -- A communication plan to manage communication and involvement of all stakeholders, including users; -- An education and training plan; -- An impact / risk assessment for the entire IT change process; and -- Defined workflows for authorizing and implementing IT changes	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1 Key Stakeholder Support	Completed	1 Acquire support and buy-in from key stakeholders (Board, committees, PAC).	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2 Current State Review	Completed	2 Understand current landscape based on assessment results.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3 Future State Review	Completed	3 Identify changes required to achieve future target state of delivery system integration.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4 Catalogue Results	Completed	4 Catalogue required changes into system-wide/PPS level, individual provider/partner level, or other and prioritize based on PPS goal of delivery system integration.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	In Progress	5 Establish process to deploy system changes at various	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
5 Change Management Process		levels (system-wide vs provider level). Process includes: - Bi-directional communication plan that addresses: 1) announces planned changes 2) determine business impact 3) determine process impact 4) forum for discussion regarding proposed change - Establish support structure and resource expectations and availability (establish roles - PPS responsibility vs partner/other party responsibility) - Create and distribute mitigation plans including temporary workarounds during change implementation and workflow changes, if any - Create training and educational materials of new processes and workflows - Conduct a post-implementation analysis ('regression testing', where applicable), to ensure changes were deployed correctly							
Task 6 Planned/Unplanned Changes	In Progress	6 Establish protocols to respond to planned and unplanned changes. Previous steps can apply to both changes based on assessments from previous milestone and any future planned or unplanned changes.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 7 Board or Other Approval	In Progress	7 Formalize process (ie formalization of Change Management Policies and Procedures), obtain required approvals, and communicate change request process to internal staff and external partners.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	In Progress	Roadmap document, including current state assessment and workplan to achieve effective clinical data sharing and interoperable systems where required. The roadmap should include: -- A governance framework with overarching rules of the road for interoperability and clinical data sharing; -- A training plan to support the successful implementation of new platforms and processes; and -- Technical standards and implementation guidance for sharing and using a common clinical data set -- Detailed plans for establishing data exchange agreements between all providers within the PPS, including care	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).							
Task 1 Establish Governance Structure	Completed	1 Establish governance structure. Director of IT (John Dionisio) will chamption development of roadmap. Acquire support and buy-in from key stakeholders including CEO (Mario Paredes), CMO (Dr Jackson Kuan), Director of Clinical Operations (Lidia Virgil), HIT Committee (Chair: John Dionisio), PAC, and Board.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2 Define Project Needs	Completed	2 Define needs of the ten projects regarding clinical data needs, connectivity and system requirements, and interoperability functionalities, including EHR interface, workflow development, clinical protocols to establish common clinical processes (which lead to common clinical data sets).	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3 Compare Results	Completed	3 Compare needs against IT Assessments results. Leverage existing processes where possible.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4 Establish Guiding Principles	Completed	4 Establish key parameters and guiding principles including: -Respect physician/practicioner's time - minimize any additional steps and maximize automation ('Let Physicians be Physicians') - System shall integrate with existing EHRs if certified. Maximize utilization of existing certified EHRs where clinical data can be aggregated and shared so appropriate providers and care management staff has access to relevant clinical history to optimize care and establishment of care plans. - Ensure training and support is readily available. - Data security is a priority. Provide proper training to key staff, key stakeholders, network providers and ensure agreements (BAAs, subcontractor DEAAs, Participation Agreements, appropriate HIPAA/HIE consent forms) are in place. - Functionalities of integrated system must adhere to evidence-based clinical protocols (ie automation of care plans for all diabetics). Any updates to clinical protocols must be incorporated in a timely manner (as part of change management system).	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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DSRIP Implementation Plan Project

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		- Follow PCMH processes where applicable to allow for singular process requirements where possible.							
Task 5 Target Operating Model Findings	Completed	5 Leverage findings from Target Operating Model workshops (facilitated by KPMG) - including Context Operating Model (to ensure requirements are traced back to functionality) and Capability Reference Model (ensure processes are comprehensive and consider various use-case scenarios likely to face ACP's operations (while considering 80/20 rule - use cases covers 80% of probable future scenarios). Additionally, utilize Business Requirements Documents and System Requirement Specifications created as a result for TOM workshops to drive workflows and systematic processes during system design of interoperable system.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6 Engage Back Office Vendor	Completed	6 ACP is expected to use a key vendor partner to provide back-office functionalities such as cell center, HIE development, centralized care management operations (ACP is stil under negotiations with vendor as of this draft and is unable to name vendor). Vendor will plan an integral role in the development of interoperable system as well as workplans and timelines.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7 Utilize Partner IT Assessments	In Progress	7 Utilize partner IT assessments to develop interoperable connectivity plan specific to each partner within ACP's network. If EHRs are certified, interface capabilities exist to connect and integrate data (HL7, CCD, CCDA, SIU, etc). Providers with non-certified EHRs or paper records will be strongly encouraged to convert to a certified EHR. As a stop-gap measure, providers in this category will utilize portal access to securely exchange information. ACP will establish and provide secure portal access and templates to providers so engagement data and clinical information is tracked (templates will allow for common data sets).	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8 RHIO Connectivity	In Progress	8 RHIO connectivity will be established to finalize interoperability and clinical data sharing.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 9 Board or Other Approvals	In Progress	9 Obtain necessary approvals to finalize roadmap.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #4 Develop a specific plan for engaging attributed	In Progress	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
members in Qualifying Entities		your approach to outreach into culturally and linguistically isolated communities.							
Task 1 Identify System Needs	Completed	1 Identify system needs, interfaces, and action plan for existing / new attributed members, ensuring culturally and linguistically appropriate needs are defined and included in plan, to engage members in QEs. Additionally, ensure outreach staff (with appropriate cultural competence and linguistic capabilities) is hired and trained. Language translation services can be used if necessary. Utilize DOH post-opt out attribution roster to determine target population.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2 Gap Analysis	Completed	2 Perform gap analysis of existing communication channels to engage with attributed members, establish strategies based on results of gap analysis. EHR demographic data as well as MCO demographic data can be leveraged and cross-referenced to ensure contact information is accurate. Any existing relationship with member will be key in physically reaching member. Outreach can be performed in various ways including direct telephonic, mailers and utilization of Community Health Worker model for hard to reach members.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3 Monitor Outreach Effectiveness	In Progress	3 Monitor reach rates to determine if outreach channels need to be modified or new channels established. Emphasize use of Community Health Worker model where literature suggests high success rates over general telephonic or mailing outreach. Health fairs and presence in community health centers can assist with engaging patients who may not be reachable using traditional methods.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 4 Ensure Continued Engagement	In Progress	4 PPS needs to ensure engaged members continue to be engaged. Various outreach including smart-phone application technologies will be explored to maintain engagement levels.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 5 Metrics	In Progress	5 Incorporate patient engagement metrics into performance monitoring to understand remaining required Scale and Speed engagements and existing care gaps.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop a data security and confidentiality plan.	Completed	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- Plans for ongoing security testing and controls to be rolled out throughout network.							
Task 1 Understand DSRIP Requirements	Completed	1 Understand DSRIP requirements for data security and confidentiality at the PPS level regarding HIPAA, HITECH, telecom, internet and cloud-based securities, mobile/wireless devices (phone, laptop, mobile drives, usb and other mobile media), at-rest and during transmission and transfer encryption of data, physical security of server rooms and employee computers, laptops and other peripherals and employee roles and responsibilities.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2 Creation of Policies and Procedures	Completed	2 Create policies and procedures to address security and confidentiality issues. Policies and procedures shall include specific sections regarding appropriate use of Mental Health, Substance Abuse and HIV data.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3 Define Access Rights	Completed	3 Establish roles and access rights to determine who can access patient records. Establish minimum necessary use and disclosure of PHI policies, including 'break the glass' policies. Policies regarding roles and access shall include proper identification and authentication of employee who is accessing records (additionally, HR policies shall include appropriate background checks of employees including review o f any appropriate exclusion lists).	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4 Data Security and Confidentiality at the Network Provider Level	Completed	4 Policies and procedures shall also include provider-level data security and confidentiality plan including adequate compliance and HIPAA training for network providers, partners and appropriate staff.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5 Contingency and Emergency Planning	Completed	5 Contingency and emergency planning policies and procedures will be developd to ensure proper protocols are in place in the event of disasters or emergency events. Policies will include: data backup plans, disaster recovery plan, emergency mode operation plan, testing and revision procedures and applications and data criticality analysis.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6 Training Policy and Timeframes	Completed	6 Appropriate training/education (as well as annual/as needed re-training and re-education) policies and scheduling will be developed to ensure all employees are aware of latest data security and confidentiality policies and to understand regular and anonymous reporting mechanisms (contact information	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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		for Compliance Officer and Privacy Officer will be distributed to all employees) in order to appropriately report issues or potential breaches.							
Task 7 RHIO/SHIN-NY Policy	Completed	7 Policies regarding RHIO and SHIN-NY connectivity will be developed that incorporates internal policies and procedures as well as RHIO and SHIN-NY policies and procedures.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	jd593813	Other	25_MDL0503_1_3_20160131183548_IT_1.2_Readiness_Survey.pdf	Readiness survey	01/31/2016 06:35 PM
Develop an IT Change Management Strategy.	jd593813	Other	25_MDL0503_1_3_20160131183726_IT_2.2-2.4_IT_Roadmap_Current_vs_Future_State.pdf	IT Roadmap	01/31/2016 06:37 PM
Develop a data security and confidentiality plan.	jd593813	Other	25_MDL0503_1_3_20160315230630_IT_5_Security_Workbooks.docx	Remediation response to IT Milestone 5 - Security Workbooks.	03/15/2016 11:06 PM
	jd593813	Policies/Procedures	25_MDL0503_1_3_20160131185020_IT_2.2-2.4_IT_Roadmap_Current_vs_Future_State.pdf	File 'IT 2.2-2.4 IT Roadmap Current vs Future State.pdf' also applies to 5.7 RHIO/SHIN-NY Policy task.	01/31/2016 06:50 PM
	jd593813	Policies/Procedures	25_MDL0503_1_3_20160131184800_ACP_-_PS_2016_01_28.docx	Security Workbook - Personnel Security	01/31/2016 06:48 PM
	jd593813	Policies/Procedures	25_MDL0503_1_3_20160131184729_ACP_-_IR_2016_01_28.docx	Security Workbook - Incident Response	01/31/2016 06:47 PM
	jd593813	Policies/Procedures	25_MDL0503_1_3_20160131184705_ACP_-_AU_2016_01_18.docx	Security Workbook - Audit and Accountability	01/31/2016 06:47 PM
	jd593813	Policies/Procedures	25_MDL0503_1_3_20160131184636_ACP_-_AT_2016_01_28.docx	Security Workbook - Awareness and Training	01/31/2016 06:46 PM

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	jd593813	Policies/Procedures	25_MDL0503_1_3_20160131184600_ACP_-_PE_2016_01_28.docx	Security Workbook - Physical and Environmental Protection	01/31/2016 06:46 PM
	jd593813	Policies/Procedures	25_MDL0503_1_3_20160131184451_IT_5.5_Contingency_Planning_Business_Continuity_and_Disaster_Recovery_Plan.pdf	Business continuity and disaster recovery plan.	01/31/2016 06:44 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	
Develop an IT Change Management Strategy.	
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	3.3 Results of survey respondents have been incorporated into overall strategy.
Develop a specific plan for engaging attributed members in Qualifying Entities	4.1 Centene, the back office vendor, has care management/care coordination system to track and monitor engagement activities. 4.2 Current communication channels primarily reside between patient and provider (and to a lesser degree, between patient and MCO). Methods of communication include direct contact, announcement or appointment request mailers and other outreach. ACP will leverage and use MCO and physician EHR demographic data to outreach to patients. ACP will also utilize community health workers (CHW) to outreach hard-to-reach patients in order to better engage them to receiving appropriate care.
Develop a data security and confidentiality plan.	

Milestone Review Status

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

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IPQR Module 5.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

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

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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IPQR Module 5.5 - Roles and Responsibilities

Instructions :

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

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

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IPQR Module 5.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

Our IT Governance Committee has established expectation with all partners to provide monthly updated reports on key performance metrics. We will monitor these performance metrics across the network to ensure continuous progress towards our IT transformation management strategy. Following is a preliminary list of the key performance measures that will be reported monthly:
- Annual gap assessment - adoption of IT infrastructure, enablement of clinical workflow, application of population analytics
- Annual update of IT strategic plan
- Annual data security audit findings and mitigation plan
- Monthly workforce training compliance report
- Monthly project portfolio 'Earned Value' report for all IT related projects within DSRIP project portfolio
- Weekly shared services performance report that includes specific performance metrics (connectivity levels, adoption and continued appropriate use of protocols and templates, PCMH roll-out plan (if provider is a PCP), project engagement requirements, medical expense performance [provider type specific, ie loss ratios, expense PMPMs for various categories within appropriate levels], quality care gap rates). Most performance metrics are binary (Yes/No, Achieved/Not Achieved) but others will need comparative data (medical expense performance, quality care gap rates)
- Weekly performance report on each IT vendor's service level agreement

IPQR Module 5.8 - IA Monitoring

Instructions :

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Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

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

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		the Compliance Committee.							
Task 4 Finalize Reporting Strategy	In Progress	4 Finalize the layered PPS-wide reporting structure: from individual providers through their associated projects' metrics and the Project Leadership Teams, up to the Advocate PPS PMO. Performance information made available by the State through MAPP and Salient will be maximally integrated into this reporting structure. We will also incorporate additional items so as to achieve the type of information needed to manage the network towards value-based payment as our PPS evolves. The final performance reporting strategy (including Rapid Cycle Evaluation process) will be signed off by the PPS Board and incorporated into the provider participation agreement. Chief Medical Officer Dr Jackson Kuan, MD and CFO Wallace Lau will be the responsible parties to ensure that clinical and financial outcomes of patient pathways are trending appropriately.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5 Education Plan	In Progress	5 Establish process and schedule for communicating / educating all participating providers and staff their respective performance metrics and reporting structure, and the relation to PPS-wide performance metrics, reporting structure, and rapid cycle evaluation.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6 Reporting Schedule	In Progress	6 Develop interim regularly scheduled performance reports to supplement the State's roll-out, tailored for each reporting layers, from individual providers through their associated projects, Project Leadership Team, PMO, Clinical Quality Committee, Finance Committee, and PPS executive body.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 7 Board Approval	In Progress	7 Finalize performance reporting and communication plan signed off by PPS Board.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 8 Establish Baseline Parameters	In Progress	8 Establish performance baseline parameters to identify high performance incentives and corrective action for low performers.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	In Progress	Finalized performance reporting training program.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1 Develop Analytics Training and Support Group	Completed	1 The Analytics Training and Support Group to train PCMH / EHR-MU support team staff on integrating new reporting	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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		processes and clinical metric monitoring workflow. There will be an initial one-time training with subsequent periodic refresher training for the trainers. The PCMH / EHR-MU support team staff will be the front-line hands-on educators for on-going assistance and support to participating providers in correct and accurate data input for data collection and reporting and reviewing the reports for timely actionable items.							
Task 2 Implementation and Training	Completed	2 In collaboration with the Clinical Quality Committee, develop provider and staff training on clinical protocol implementation, performance reporting, rapid cycle evaluation, and communications, leveraging on existing provider organization group meetings. Monthly group meetings began in DY0 and will continue throughout the DSRIP term. Training covers provider and staff roles and responsibilities. Training will include the full range of providers in addition to physicians and their staff; hospital triage / ED staff, home health providers, long term care, behavior health providers, community-based service providers, etc.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3 Training Schedule	Completed	3 Schedule and roll out training to all network providers, leveraging on their respective existing meeting of peer groups and hubs for more efficient training schedules and venues. These will include physician offices, as well as hospital triage / ED staff, home health, long term care, behavioral health, community-based services, etc. ACP will start with monthly meetings in DY1 and then transition to quarterly meetings when appropriate.	10/01/2015	10/31/2015	10/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task 4 Metrics Reporting Training Effectiveness	In Progress	4 Establish feedback loop to guage training effectiveness. Providers will be periodically surveyes to check understanding of new policies and procedures established to improve clinical quality. Providers will be provided with monthly/quarterly performance reporting, but as important, follow up items at actionable levels (often at the member level). As with milestones listed under Financial Sustainability, adequate support such as a provider engagement team and formal/informal education and training, will be available to ensure providers meet the requirements of DSRIP.	10/31/2015	03/31/2016	10/31/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		Additionally, continual review of performance reporting will highlight providers who require additional training (ex. low care gap completions rates, low patient engagement rates).							
Task 5 Identifying Performance Champions	In Progress	5 In collaboration with leadership staff (Officers and Directors), the training team to identify primary contact at each site and encourage to become performance champions to help cultivate performance reporting culture and ongoing fine tuning of performance reporting, communication plan, rapid cycle evaluation process.	10/31/2015	03/31/2016	10/31/2015	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Establish reporting structure for PPS-wide performance reporting and communication.	jd593813	Other	25_MDL0603_1_3_20160131185458_Performance_Reporting_1.1-1.3_IT_Roadmap.pdf	IT Roadmap that addresses reporting and analytics.	01/31/2016 06:54 PM
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	jd593813	Other	25_MDL0603_1_3_20160202182544_Performance_Reporting_2.3_Physician_Training_Schedule.xlsx	Physician Training Schedule	02/02/2016 06:25 PM
	jd593813	Other	25_MDL0603_1_3_20160131190202_Performance_Reporting_1.1-1.3_IT_Roadmap.pdf	File 'Performance_Reporting_1.1-1.3_IT_Roadmap.pdf' also applies to tasks under Milestone 2.	01/31/2016 07:02 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish reporting structure for PPS-wide performance reporting and communication.	
Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	2.1 Performance reporting training includes communication of defined metrics, baselines, and initiatives (as described in the IT Roadmap) that allows for avenues of immediate feedback in order to evaluate rapidly.

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Milestone Review Status

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

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IPQR Module 6.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

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

IPQR Module 6.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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IPQR Module 6.5 - Roles and Responsibilities

Instructions :

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

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

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IPQR Module 6.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 6.7 - IT Expectations

Instructions :

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

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

IPQR Module 6.8 - Progress Reporting

Instructions :

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

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

IPQR Module 6.9 - IA Monitoring

Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

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

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		participation in physician engagement meetings.							
Task 4 Develop Physician Engagement Teams	Completed	4 Develop physician engagement teams which will provide on site support and guidance to practitioners. These teams will periodically visit the practitioners and maintain active contact with them to encourage compliance and serve to liase between the individual practitioner and the PPS.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 5 Develop Physician Engagement Plan	Completed	5 Develop a practitioner engagement meeting plan with established PPS wide practitioner meetings to provide updates on implementation and performance and provide the practitioner a platform for actively providing feedback and discussing any issues.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 6 Develop DSRIP Protocol Manual	Completed	6 Develop user friendly materials for distribution to physicians on DSRIP processes and procedures including reporting metrics, Evidence based protocols, procedure manuals for support.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 7 Develop Reporting Metrics and Benchmarks	Completed	7 Develop reporting metrics and benchmarks to be used to monitor compliance with DSRIP measures and provide training to practitioners on each measure. Metrics include patient engagement, care gap close rates, care plan compliance, etc.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Completed	Practitioner training / education plan.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task 1 Develop Education Campaign	Completed	1 Develop educational campaign and training venue for practitioner that provides information on Key Goals and Objective of the DSRIP program by Lidia Virgil, Director of Programs.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 2 Develop Evidence-Based Protocols	Completed	2 Develop and disseminate evidence-based protocols for project implementation and performance.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 3 Develop Procedure Manual and How-to's	Completed	3 Develop procedure manuals and how-to workflow tools for documenting procedures.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 4 Develop Performance Reporting	Completed	4 Develop downstream reporting to present to individual practitioners regarding individual performance and corrective action plans for quality improvement.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 5 Hold Practitioner Engagement Meetings	Completed	5 Hold PPS wide practitioner engagement meetings to educate on DSRIP goals and requirements.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task 6 Develop ACP Website Repository	Completed	6 Develop ACP website and include all DSRIP support information, ACP procedures, processes, protocols and reporting structure.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	jd593813	Policies/Procedures	25_MDL0703_1_3_20160316113538_Practitioner_Engagement_2_-_Physician_Engagement_Process.pdf	Remediation response to Practitioner Engagement Milestone 2 - Physician Engagement process	03/16/2016 11:35 AM
	jd593813	Templates	25_MDL0703_1_3_20160315234722_Practitioner_Engagement_Milestone_2_Training_Schedule_Template.xlsx	Remediation response to Practitioner Engagement Milestone 2 - Meeting Template	03/15/2016 11:47 PM
	jd593813	Training Documentation	25_MDL0703_1_3_20160315234439_ACP_Physician_Engagement_2015_11_17.pptx	Remediation response to Practitioner Engagement Milestone 2 - Training materials for providers.	03/15/2016 11:44 PM
	jd593813	Other	25_MDL0703_1_3_20160131190940_Practitioner_Engagement_2.6_Website_Address.pdf	Website repository address	01/31/2016 07:09 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	2.6 Website repository of training materials is http://acppps.org/documents-and-surveys

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Milestone Review Status

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

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IPQR Module 7.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

Practitioner engagement is the initial and ongoing initiative with active and committed practitioners. A substantial portion of the ACP practitioner community currently has a significant interest in the DSRIP program since the program affects their clients, the Medicaid recipients.
Lack of Practitioner Champions and Influencers: The first major risk is that we don't find a sufficient number of practitioners who are willing and able to take time away from their day job to become significantly involved with ACP in this critical stewardship role. To mitigate this we look to attract those practitioners who are currently leaders in the clinical community and who have shown a strong interest in DSRIP. We also intend to find back-up leaders who are willing and able to step in should the first set of champions and influencers have to step out for whatever reasons.
Physician Behavior Change: Practitioners are in the business of healthcare and therefore the required core behavior changes vital to DSRIP transformation are likely to affect their practice styles and their practice financial situations. This will make it difficult for practitioner champions and influencers to get the average practitioner's buy-in. To mitigate this risk we will establish a value based payment program that rewards practitioners for changing their behavior. Community practitioners are likely to show a resistance to "cookbook medicine" including the adoption and adherence to EBM, clinical protocols and paths. To mitigate this practitioner leaders must be willing and able to model the behavior change required and educate their peers on the necessity to change in order to survive in the future health care system. The development of financial incentives for short run behavior modification and value-based payment in the long run behavior change is a key component of practitioner engagement.
Administrative Support: A majority of the activities surround provider engagement are at the grassroots level. Engagement teams must be very efficient, properly trained, develop lasting relationships and have the ability to cover large territories (ie borough-wide) to ensure provider engagement, training and re-training are adequate. This group will be the main point of contact with the PPS network.

IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

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

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Practitioners will need much support and a well trained staff in order to provide the best and most efficient, cost effective care, which in turn shall produce success in all DSRIP goals.

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IPQR Module 7.5 - Roles and Responsibilities

Instructions :

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

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

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IPQR Module 7.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 7.7 - IT Expectations

Instructions :

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

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

IPQR Module 7.8 - Progress Reporting

Instructions :

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

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

IPQR Module 7.9 - IA Monitoring

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Instructions :

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Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1 Identify Hotspots	Completed	1 Based on the CNA results, identify population hotspots, both in the PPS area and in specific geographic areas, to target those with greatest needs within each of the chosen projects. Solicit participating providers' feedback before finalization.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2 Distribute Protocols	Completed	2 Distribute protocols/ care guidelines for providers on engaging and treating target population. Establish metrics for each clinical area to monitor progress in managing population health.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3 Create Reporting Dashboard	In Progress	3 Create a dashboard that can be easily accessed by all participating providers to monitor population health outreach and patient engagement and compliance.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4 Create Workgroup	In Progress	4 Create Clinical Operations/IT Workgroup to establish population health criteria with metrics to incorporate within integrated delivery system design.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5 Data Inventory	In Progress	5 Inventory available data sets with individual demographic, health, and community status information , to supplement our use of the data available through available state tools such as	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		MAPP tool, etc.							
Task 6 Database Development	In Progress	6 Develop a relational database for individual care management. Perform data analyses to identify target population through algorithms and registries; identify priority practice groups to have access to registries	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7 Workforce Assessment	In Progress	7 Complete workforce assessment for priority practice groups' care management capabilities, including staff skills and resources required to manage priority at risk populations in each geographic area. Develop workforce training / re-training / support staff assignment to mitigate workforce gaps.	04/01/2015	03/30/2016	04/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 8 PCMH	In Progress	8 Establish PCMH / EHR-MU Certification Team and vendor support to identify key gaps and develop plan to achieve Level 3 certification by DY3.	10/01/2015	03/30/2016	10/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 9 Support Staff Deployment	In Progress	9 Deploy staff support at provider level to train providers to use and apply information learned from registries; how to implement established care guidelines; develop disease pathways; inform on metrics for monitoring progress in managing population health; implement plan to achieve PCMH Level 3 certification by DY3.	10/01/2015	03/30/2016	10/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 10 Promotional Education Materials	Completed	10 Create promotional educational materials and distribution plan for population wide health campaigns	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 11 CBO Engagement	In Progress	11 Work with CBOs and other PPS's in reaching target populations, disseminating materials in a culturally sensitive manner in the promotion of population health and specifically those projects chosen by ACP PPS.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 12 Finalize CBO Agreements	In Progress	12 Finalize Agreements with CBOs for the provision of services related to population health in specific projects such as tobacco cessation, sex education, cancer prevention, etc.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 13 Finalize Roadmap	In Progress	13 Clinical Quality Committee to finalize population health management roadmap	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1 Establish Service Utilization Monitoring Team	Completed	1 1. Establish Service Utilization Monitoring Team (SUMT) with partner hospitals and behavioral health units / facilities.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		This team will report to the PMO and Clinical Quality Committee and will be responsible for monitoring and reporting on reductions in avoidable hospital use and modeling the impact of all DSRIP projects on inpatient activities. Team will collect and produce utilization reports based on bed type (BH, Med/Surg, OB/Maternity) and utilization in the ED to ensure appropriate metrics are developed for each bed type and department.							
Task 2 Data Analysis	In Progress	2 SUMT to analyze and model the impact of all DSRIP projects on avoidable hospital use and utilization of hospital services (inpatient and outpatient) and demand for community-based services. Model can be updated regularly (monthly or quarterly)	10/01/2015	03/30/2016	10/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 3 Data Forecasting	In Progress	3 Based on the modeling and in consultation with provider network, establish a high level forecast of: - Reduced avoidable hospital use over time - Changes in inpatient capacity (including BH, Med/Surge, OB/Maternity and others) - Resulting changes in community / outpatient / ED capacity (non-psych/MH/SUD ED and psych/MH/SUD-ED)	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 4 Draft Capacity Plan	In Progress	4 SUMT to lead consultation on first draft capacity change plans	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 5 Publish Capacity Plan	In Progress	5 Finalize and publish final capacity change / bed reduction plan and schedule updates of capacity changes across the network	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop population health management	jd593813	Other	25_MDL0803_1_3_20160202183103_Population_	CNA	02/02/2016 06:31 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
roadmap.			Health_1.1_Community_Needs_Assessment.pdf		

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	1.2 Protocols created and distributed that provide guidelines for engaging target population. 1.10 Educational materials are located at this address: https://acppps.mynurturlife.com/Security/Authentication/Login
Finalize PPS-wide bed reduction plan.	2.1 Service Utilization Monitoring Team includes Lidia Virgil and John Dionisio with ACP, Angelo Canedo with Medisys and Catherine Shih/Grace Wong with Northwell hospitals.

Milestone Review Status

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

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IPQR Module 8.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

Provider and Staff Culture: Changing the culture of how services are delivered represents a true challenge in the area of population health. At present, the healthcare system is set up in a way that care is delivered on a one on one basis and is delivered in the face of specific conditions, to address those specific conditions. In the population health projects, the PPS will need to address conditions that a patient and/or member of the target population may not have yet. The culture of all of the practices must be changed to a more predictive and proactive method. This will be difficult as it represents additional expenses at little or no reimbursement since at present, there is little to no reimbursement on the part of payers for preventive services. The PPS aims to mitigate this risk by negatiating with payers, MCOs to provide reimbursement for educational visits, and other preventive care services. The PPS will also mitigate this risk through the training and retraining of its providers in the provision of preventive care services. Another way to mitigate this risk is through population wide campaigns through several methods, achievable with the help of Commmunity partners.
Patient Engagement: Another risk is in effectively reaching out to and engaging the at risk populations. ACP plans to mitigate this risk with the use of Community Health Workers/Health Advocates who have direct connections with the community and share cultures and language with the patients.
Population Health Analytics: Another risk is that population health data analyses are time consuming and expensive and it takes a long time for organizations to develop new services or interventions. To mitigate this risk, we plan to start with available high level data at hand from our CNA, refine them and apply them at actionable levels first and then supplement them with the more detailed data analyses.
Continue population health management approach: To facilitate continued education and cultivation of the population health management approach, we will improve on our communications and workforce training strategies to ensure meaningful education on population health management.

IPQR Module 8.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Successful implementation of multiple workstreams will contribute significantly to the development of effective population health management across ACP PPS.
1. Effective and rapid communication and data sharing will be used to ascertain defined target and outreach methodology for implementation of population health initiatives Thus, a robust and functional set of data gathering and monitoring tools surveys, CNA, registries shall be implemented with the IT platform functionality.
2. Population Health will also be highly dependent on workforce as it will require staff re-training as well as new staff deployment including community health workers/health advocates, etc.

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3. Finance has an integral role in population health management since all campaigns and new systems and processes will require a financial commitment from the PPS to cover high costs of same.
4. Governance in all of its forms will play a key role since agreements with CBOs, community leaders, other PPS' will have to be in place for shared information and outreach. The PMO will have direct intervention in since it will distribute and implement protocols and processes for patient engagement and intervention.
5. Another major dependency is the Provider Engagement team, who will have to provide the providers with information, training materials and achieve provider buy in and support. Training or re-training of care managers, care coordinators, and other care team support staff would also be a key dependency for our network providers. In addition, an integrated delivery system where information technology are leveraged for clinical care would help to round out the tool set for the population health management care team.
6. Cultural competency is also important in educating and engaging patients in taking appropriate action and changing health behaviors in the PPS' population health projects of tobacco cessation and prevention of chronic diseases.

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IPQR Module 8.5 - Roles and Responsibilities

Instructions :

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

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

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IPQR Module 8.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 8.7 - IT Expectations

Instructions :

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

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

IPQR Module 8.8 - Progress Reporting

Instructions :

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

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

IPQR Module 8.9 - IA Monitoring

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Instructions :

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Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	In Progress	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1 Perform IT Assessment of Network	Completed	1 Survey of all providers to determine electronic record, connectivity, and data sharing capabilities, leverage existing systems where applicable, identify gaps in readiness, staffing, workflows. Create assessment tool to determine readiness and capabilities of providers within the network. Director of IT, John Dionisio, with support from clinical operations team (lead: Lidia Virgil) will be responsible for the conducting of the survey (however potential vendor assistance may be an option). Survey questions are aimed to gather information on partner IT structure (centralized, independent, outsourced), operating system compatibility, EHR type, experience with electronic data feeds, MU/PCMH certification, Care Coordination processes and workflows, patient engagement and communication and information exchange capabilities.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2 Review Assessment Results	Completed	2 Use survey and assessment tool results to determine capabilities of each individual provider's electronic system for	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		integration; gauge individual provider level of preparedness for EMR and level 3 PCMH certification.							
Task 3 Determine Provider Preparedness Level	In Progress	3 Determine individual provider level of preparedness for practice workflow restructuring based on current staff and future staff needs, as well as staff educational status and need for retraining. Establish acceptable transition plan with provider if necessary that includes re-training of staff and introducing potential centralized functions that ACP will retain.	10/01/2015	03/30/2016	10/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 4 Document Results	In Progress	4 Document results and compare against future state. Determine final roll out plan. Gather Board approvals where necessary.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5 Ensure Provider Readiness for Integrations	In Progress	5 Develop and roll out process to ensure provider readiness for integration, where gaps exist.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task 1 Define Project Target State for Clinical Integration	Completed	1 For each DSRIP project: define with the project group what the target clinical integrated state should look like from a people, process, technology and data perspective (including assessment and care protocols and specific attention to care transitions). Identify the main functional barriers to achieving this from the perspective of both provider organizations and individual clinicians. Currently ACP has been a participating PPS with KPMG in the creation of the TOM system, which has provided a basis for integration.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2 Determine Gaps Between Current and Target	Completed	2 Based on this target state and the gaps identified in the integrated care needs assessment, define and prioritize the	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
State		steps required to close the gaps between current state and desired end state (in terms of the needs for people, process, technology and data).							
Task 3 Transition Paper-based Providers and Non-Certified EHR-based to Certified EHR	Completed	3 Contact providers without EHRs or those with non-certified EHRs as identified in gap analysis and provide contracts for EHR implementation. ACP will support providers and provide assistance and support with implementation of EHR.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4 Develop PCMH Implementation Plan	In Progress	4 Contact providers identified in gap analysis and implement plan as in project 2.a.i regarding achievement of PCMH level 3 certification.	10/01/2015	03/30/2016	10/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 5 Establish Referral Pathways	In Progress	5 Establish referral pathways of integration in which referrals flow between partners in an efficient electronic fashion that can be monitored and in accordance with implemented evidence based protocols and best practices.	10/01/2015	03/30/2016	10/01/2015	03/30/2016	03/31/2016	DY1 Q4	
Task 6 Identify Common Processes for Each Project	In Progress	6 Identify the common steps required for each project. For example: the need for supportive IT infrastructure to enable data sharing.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7 Identify Key Clinical Data Required	In Progress	7 Conduct engagement exercise with practitioners and other stakeholders, focused on identifying the key clinical (and other) data that will be required to support effective information exchange at transitions of care	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 8 Create Care Coordination and Provider Education Program	In Progress	8 Create care coordination and provider education program and schedule including training and strategies to use based on provider	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 9 Define Incentives	In Progress	9 Define incentives to encourage the behaviors and practices that underpin the target state (e.g. multi-disciplinary care planning). These incentives might include financial / personnel support to providers looking to improve the efficiency of their operations in order to create more time for coordinated care practices; or the creation of shared back office service functions to improve the efficiency of provider organizations.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 10 Clinical Integration Stakeholder Input	In Progress	10 Consult internal and external stakeholders (including patients) on draft clinical integration and transformation strategy.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 11 Finalize Strategy	In Progress	11 Finalize PPS strategy and roadmap document on clinical integration across all projects.	06/01/2016	09/30/2016	06/01/2016	09/30/2016	09/30/2016	DY2 Q2	

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IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a Clinical Integration strategy.	jd593813	Other	25_MDL0903_1_3_20160131195001_Clinical_Integration_2.2_IT_TOM.pdf	Gaps from use-case scenarios analyzed during IT Target Operating Model discussions with KPMG.	01/31/2016 07:50 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	1.1-1.2 Results of survey respondents have been incorporated into overall strategy.
Develop a Clinical Integration strategy.	2.3 Known physicians and other providers with paper medical records have been outreached to and presented with options to transition to EHR. Alternatively, a portal option that incorporates into the office or facility workflow has been presented as well.

Milestone Review Status

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

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IPQR Module 9.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies

Instructions :

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

IT/EHR Adoption: One of the risks is that some providers may be reluctant to adopt EHRs within tight timeframe to achieve MU 1/2, PCMH Level 3, and to be linked into the clinically interoperable system within the tight timeframe. ACP will provide the providers with support and training through its support center, "hub", in order to help alleviate anxiety and provide efficiency of implementation. Strong provider engagement and buy in is key to this process, therefore the provider engagement team will schedule and run training meetings as well as do individual outreach and surveying of provider status, providing the support teams and governance with readiness and specific action plans.
Referral and Patient Tracking: Another risk is in tracking patient compliance with referrals as coordinated by PCP or specialist providers with such a vast network of providers and such a low health literacy rate we understand that patients tend to seek care through word of mouth in the communities more than through standard evidence based channels. The PPS will mitigate this risk by fostering strong relationships within the community with PCPs, CBOs and providing patient educational campaigns and one on one coaching by the PCP, Care Coordinators and Case managers. The support center, "Hub" care coordination staff will maintain open lines of communication with the patients and provide follow up with them to ensure fulfillment of the referrals and the flow of information to and from PCP and specialty services. The PPS also will use its strength of having such a vast network to ensure that all partners are clinically integrated and have open lines of communication via electronic platform with the ability to share all pertinent patient information so as to track our patients wherever they may receive care. All PPS partners will communicate with central office, (Hub) regarding patient services.
System Integration: Another risk is related to the inadequacy of certain provider's systems for integration. The PPS will mitigate this by creating a platform that is interconnected to many types of systems as well as partnerships with EMR and systems vendors that will provide lower cost systems with stronger support to our partners. The PPS' support center/hub will provide the providers with support, training and assistance. IT policies and process must account for this dependency and create potential workarounds.

IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Major dependencies for Clinical Integration are mostly all other aspects of the full implementation plan.
1. Adoption of EHR by all providers is in it's own rite a major dependency since HIE must be timely, efficient and up to the moment.
2. Adoption of PPS clinical protocols and processes by all providers throughout PPS must happen for a successful integration.
3. Governance model must be operational for clear and consistent communication of all providers and follow through, monitoring, incentives for compliance.
4. Clinical integration has a major dependency on workforce strategy. The workforce will need to supply the additional staff needed for implementation of clinical integration, provider engagement and support center staff as well as current staff retraining.

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IPQR Module 9.5 - Roles and Responsibilities

Instructions :

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

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

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IPQR Module 9.6 - Key Stakeholders

Instructions :

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

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

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IPQR Module 9.7 - IT Expectations

Instructions :

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

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

IPQR Module 9.8 - Progress Reporting

Instructions :

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

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

IPQR Module 9.9 - IA Monitoring:

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Instructions :

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Section 10 – General Project Reporting

IPQR Module 10.1 - Overall approach to implementation

Instructions :

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

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

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

In addition to the general framework for DSRIP, ACP intends to approach project implementation in several ways. All projects will follow:
1. Creation and implementation of evidence-based protocols. ACP has developed and drafted evidence-based and process manuals to support quality treatment of its patients and a consistent approach to care. Each protocol also has been condensed into shorter summaries for easier approach and understanding by providers.
2. Creation of a support center who will provide ongoing support to all of ACP's providers. This will consist of IT Support, Outreach, Care Coordination/Management, and Reporting/Analytics staff.
3. ACP has Physician Engagement teams who shall be the first line of communication with providers and staff to provide ongoing outreach and training. The Physician Engagement teams will be comprised of staff of the same culture and regional area as the providers. The processes will provide the tools that providers will need to be successful without implementing new workflows on their own. Many times the providers treat all of the conditions addressed in the DSRIP projects in a vacuum and without support, causing them to not being able to provide close monitoring and follow up. ACP's implementation plan takes the providers current workflows and promotes higher rates of compliance and quality care.
4. The project implementation process will be guided and overseen by Directors and the clinical quality committee. Progress will be monitored through metrics developed bymACP for reporting which will include MU and PCMH quality reporting as well as claims data, CDSS alerts and other ACP quality metrics.
5. Throughout all of ACP's projects, ACP will work collaboratively with all other PPS' and will include joint campaigns for population health, health

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literacy and community engagement and project specific initiatives including patients receiving services for care transitions and ED triage.

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

Instructions :

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

Many interdependencies exist between ACP's DSRIP projects. These interdependencies live in the major IT infrastructure that ACP is developing with an interconnected IT platform that will allow for real-time data sharing between providers and fostering of exquisite care coordination. A care coordinator and PCP staff will be able to follow a patient from the point of initial contact through the referral and consult back process, never losing site of the patient status and care. All PCPs will attain PCMH level 3 status thus improving the quality of care and care coordination of their patients. ACP's protocols are comprehensive and extensive and cover many often-missed elements of disease care which involve and intertwine with care for comorbid conditions also addressed in other of ACP's DSRIP projects. Several of the projects being implemented by ACP have several synergies in their treatment plans and approaches to care and many patients have comorbidities corresponding with the disease specific projects being implemented. ACP plans to capitalize on these synergies to avoid duplications and create more efficient treatment of patients and increased patient engagement. ACP will have staff that is trained in several aspects of care and not just one project, to address those patients with comorbidities, or more than one condition pertaining to more than one of our projects. For example a Diabetic who also has Hypertension and who will receive Lifestyle coaching and disease management techniques for both diseases will receive care from one PCP and be followed by the same care coordination and case manager. This alignment creates a greater rapport between the patient and the practice/staff and translate into increased compliance.
With respect to overlapping project requirements, we have mapped these out in a matrix format showing the cross-cutting of requirements. For those project requirements that are most pervasive, we have set up specific work teams tasked with ensuring consistent and coordinated implementation. The achievement of PCMH 2014 Level 3 certification is one example - we have a dedicated PCMH / EHR-Meaningful Use (MU) team that will be responsible for assisting all relevant providers to meet this project requirement according to the timetable set out in speed and scale commitments. This work team will be responsible for the overlapping requirements of using EHRs to track all patients engaged in projects and ensure all EHR systems used by participating safety-net providers meet MU and PCMH Level 3 by the end of DY3.

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

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IPQR Module 10.3 - Project Roles and Responsibilities

Instructions :

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

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

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Labor Union (Helen Schaub)	Labor representation	Participate on Workforce issues, agreements and documents,

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

Instructions :

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

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

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		practices (ie FFS transition to Level III VBP). Ensure PCMH reimbursement program continues to assist physicians with upkeep of PCMH certifications.

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IPQR Module 10.5 - IT Requirements

Instructions :

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

After the conclusion of the IT Target Operating Model discussions with KPMG, several documents were created to capture the requirements for the two projects that were highlighted (2ai Integrated Delivery Service and 3ai Integration of Primary Care and Behavioral Health):
-Business Requirements Document – this document highlighted the processes and systems needed to accommodate the workflow discussed during the use case scenarios presented, specific to ACP's needs. Tremendous focus was placed on coordination, given ACP's network of independent community-based providers, so that care is delivered to the patient appropriately, timely and efficiently. ACP's vast network of safety net providers provides care to patients with various clinical and socio-economic needs. As part of the discovery process, many use cases, aside from the three that were scrutinized, would require the support and services of Community Based Organizations (CBOs). Additionally, culturally competent support is required to navigate the overall healthcare system at the community level, or after an event has occurred at the institutional setting (ie inpatient admission).
-Systems Requirement Specifications – this document identified the key systems and processes required to be able to streamline workflows and accommodate information from a variety of sources. System interfaces such as HL7, CCDs, amongst others, will be used to connect various providers together. ADT feeds will also be a key interface to bring real time alerts to physicians so that they are aware of patients who are receiving services in institutional settings.
These two documents will be used to create ACP's Integrated Delivery System that will support all projects. Key framework components will include:
-Care Management/Care Coordination system which will be the source of outreach for ACP to patients, providers and other organizations to assist with patient navigation and coordination.
-Analytics platform which will identify patients with care gaps, those with chronic conditions or those who seek care in inappropriate settings (ie repeat visits to the ED).
-Health Information Exchange will be developed leveraging the capabilities of existing EHRs. Centralization of data will be key so information can be consolidated for population health activities and other data-driven reporting. Analytics functions will provide support.
-RHIO connectivity is also part of the plan in order to satisfy DSRIP requirements.

IPQR Module 10.6 - Performance Monitoring

Instructions :

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

Data captured from a variety of sources, such as the state, MCOs, provider EHRs, will provide the Analytics function to be able to create performance reporting as it relates to DSRIP. ACP will develop a robust Analytics function as part of the general Integrated Delivery Service framework. General benchmark data ('Attribution Benchmark' and 'Panel Benchmark') will be used to provide providers with knowledge of their

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level of patient engagement as defined by the DSRIP projects. Attribution Benchmark is defined as patient engagement counts relative to DSRIP attribution. Panel Benchmark is defined as patient engagement counts relative to a provider's Medicaid and Medicaid Managed Care rosters. Additionally, quality, expense, utilization and clinical data reporting will be provided as tools to assist providers to target areas of opportunities with their panel, as well as immediate surrounding population. Quality reports will identify preventive care gaps that continue to exist. Expense and utilization reporting will give a provider insight into the expense patterns of his/her patients and the community. Clinical data will be used to ensure patients are receiving the right services based on health history of the patient.
As the transition to value-based payments occurs, these reporting sets will evolve to give providers a better understanding of actionable next steps to ensure success in the value-based settings. MCOs will play a strong part in providing some operational support to ensure data is accurate and complete. ACP will leverage MCO expertise to ensure that all areas of opportunities are identified and initiatives deployed to further the success of provider's role in a value-based setting.
Overall, ACP will encourage providers to review reporting and take the next actionable steps in order to improve on areas of opportunity. ACP will provide tools (such as the care management and care coordination functions) to assist providers achieve initiative goals.

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IPQR Module 10.7 - Community Engagement

Instructions :

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

General Approach
ACP approach recognizes that the success and sustainability of DSRIP in the years to come will largely ride on our ability to creatively align and re-engineer community resources. A successful re-engineering entails the creation of new and more vibrant lines of communications and relations among providers, governmental entities and a diverse patient population. Institutional reforms, the introduction of evidence-based protocols and population health management interventions will create the foundation for the financial sustainability of the PPS. However, the successful engagement, involvement and active participation of the community will ensure sustainability. In this regard ACP envisions Medicaid recipients as active agents in the management of their healthcare and the most critical element of success. By success we refer to the overall goal of making the community healthier.

ACPs concern for community involvement drove the creation of the PPS. ACPs providers are community grounded. The medical practices are neighborhood based and some of our hospital partners even bear the name of the main community within their target area: Jamaica Hospital, Flushing hospital, Forest Hills Hospital, etc. The CBOs in our network are also firmly based in community. The staff of the medical practices are largely from the surrounding communities and form part of the larger landscape.

Risks
Poor provider integration
Ineffective CHW integration into PPS delivery structure
Increased demand for service falling behind the supply

Major Elements of the Plan
1. Using the Medical Practice as the "Organizing Principle" for Community Engagement
2. The Community Health Worker Program
3. Communication Strategy
4. Cultural Competency Vision and Initiative

Major Initiatives
1. The Community Based Organizations Partnership Program (CBOPP)
2. The Waiting Room Project
3. Community Resource Mapping Exercise
4. "Health Week" Engaging the Health Business Industry
5. Get Focused on Reading and Exercising" Campaign Targeting Children and parents in afterschool Programs
6. Public agency Coordination Plan

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ACP will establish the Community Based Organizations Partnership Program (CBOPP) as the main vehicle for contracting with CBOs. As the health system for Medicaid recipients moves from hospitals to ambulatory settings and from episodic to care management and coordination; prevention, outreach and community engagement have taken a more prominent role in the delivery of health care. With over 650,000 patients in every community in the Bronx, Brooklyn, Manhattan and Queens, ACP is looking for community-based partners to more effectively engage and serve its patient base. Overall goals include: Integration of CBOs into the work of ACP within target areas and establishment of a base of community support for ACP projects and activities.

ACP will achieve the stated goals and objective through:
1. Development of written partnership agreements
2. Establishment of the "Advocate Fund" to engage CBOs
3. Involvement of CBOs in a wide range of activities that include but are not limited to:
a. Health promotion and education,
b. Cultural competency,
c. Health literacy,
d. Disease management education, others.

IPQR Module 10.8 - IA Monitoring

Instructions :

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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending

Instructions :

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

Funding Type	Year/Quarter										
	DY1(Q1/Q2)($)	DY1(Q3/Q4)($)	DY2(Q1/Q2)($)	DY2(Q3/Q4)($)	DY3(Q1/Q2)($)	DY3(Q3/Q4)($)	DY4(Q1/Q2)($)	DY4(Q3/Q4)($)	DY5(Q1/Q2)($)	DY5(Q3/Q4)($)	Total Spending($)
Retraining	1,055,072	6,696,178	2,984,231	5,542,144	2,848,584	5,290,228	2,441,644	4,534,481	2,305,997	4,282,566	37,981,125
Redeployment	237,391	1,506,640	671,452	1,246,982	640,931	1,190,301	549,370	1,020,258	518,849	963,579	8,545,753
Recruitment	19,783	125,553	55,954	103,915	53,411	99,192	45,781	85,022	43,237	80,298	712,146
Other	166,174	1,054,648	470,016	872,888	448,652	833,211	384,559	714,181	363,195	674,503	5,982,027

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

First year: DY1 Q1/Q2/Q3 based on actual admin expenses and funds flow distributions. Remaining DY1 workforce dollars pushed to Q4.

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IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	On Hold	Finalized PPS target workforce state, signed off by PPS workforce governance body.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	NO
Task 1 Workforce Committee	On Hold	Formation of ACP Workforce Committee (WC) who will review workforce strategies and provide feedback, monitoring and advice. The committee includes members from labor as well as PPS Project Managers/Directors, providers and staff. The committee utilizes stakeholders and subject matters experts to inform its work.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 2 Project Requirements Analysis	On Hold	Conduct an in-depth analysis of the requirements of each project in order to determine any changes to the a new service delivery structure of the PPS	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 3 Organizational Impact Assessment	On Hold	Complete Organizational Impact Assessment, determine the project by project impact on the workforce of each of the four sectors: hospitals, physicians, cbo partners, and PPS. The assessment information will be utilized to make projections about the potential impact on the workforce and to make decisions about the need for re-training and re-deployment of staff. The WC to identify/develop instruments (surveys and forms) to conduct the assessment. The assessment is specific and includes the impact on mission, organizational structure, staff lines, talent, organizational culture, budgets, and strategic plans.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 4 Creation of Workforce Portal	On Hold	The WC works with the IT Director to implement a web based monitoring mechanism to track training effectiveness and impact. The system will send alerts and brief questionnaires to each traininee after completion of initial training and to key administrative personnel to gather information about the level of job related knowedge and skill, job efficiency and	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		effectiveness of newly trained personnel. The data will be obtained and reviewed again in 6 month interval after completion of training with implementation of corrective action plans to follow if needed. Every corrective plan of action is monitored consistently an d more formally reviewed after a 6 month interval.							
Task 5 Workforce Strategy	On Hold	Complete Future State Workforce strategy analysis and needs assessment. These reports will note the wide range of knowledge, skills, and attitudes required to support the DSRIP projects across all sectors and suggest the level of support that each sector of the PPS will require in order to successfully implement each project.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 6 Current State Analysis	On Hold	Workforce current state analysis report presented to PPS Governing Body for review. Analysis to include current state and impact on DSRIP project implementation and achievement of goals.	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 7 Analysis Approval	On Hold	PPS Governing Body reviews and approves Target Workforce state analysis and approves considering budget, impact analysis .	10/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	On Hold	Completed workforce transition roadmap, signed off by PPS workforce governance body.	07/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	NO
Task 1 Develop Recommendation Process	On Hold	Establish a process for making recommendations to the governing body regarding the allocation of workforce resources; identify key players and "decision-makers;" the decision making body to be fully representative of the PPS.	07/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 2 Draft Roadmap Development	On Hold	The Workforce Committee hires a SME to provide a preliminary draft of the "roadmap" that is based on the current state of the workforce and the desired future state. The roadmap includes the components, elements, steps and timeline for each sector of the workforce. The WC reviews the report and submits to the PAC and then the Steering Committee for additional input.	10/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 3 Roadmap Approval	On Hold	Finalize the transition roadmap and present to the PPS Governing body for review and approval.	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #3 Perform detailed gap analysis between current	On Hold	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
state assessment of workforce and projected future state.									
Task 1 Future State Gap Analysis	On Hold	Conduct gap analysis of current state versus future state based on a detailed comparison of positions and competencies across each of the four sectors. The report is thorough and specific to all projects and staff positions, and identifies gaps in the staff structure of the overall PPS, and need/opportunities for re-training and re-deployment maximizing the overall talent pool and ensuring readiness.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 2 Workforce Budget	On Hold	Complete preliminary draft of 5 year Workforce budget based on the gap analysis and other Workforce Implementation Plan deliverables.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 3 Complete Analysis	On Hold	Review and complete gap analysis report.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 4 Finalize Budget	On Hold	Complete final workforce budget based on gap analysis results	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 5 Approve Analysis Report and Budget	On Hold	Gap analysis report and final workforce budget approved by the PPS Governing body.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	On Hold	Compensation and benefit analysis report, signed off by PPS workforce governance body.	10/01/2015	09/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Task 6 Comp Plan Approvals	On Hold	Compensation and benefit report and package reviewed and approved by PPS Governing body	01/01/2016	09/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 5 Policy for Staff Declining Retraining	On Hold	Develop policy recommendations for staff partially placed and/or who refuse new re-training and deployment.	01/01/2016	09/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 1 Identification of Staff to Retrain	On Hold	Identify all staff lines to be retrained/redeployed across all sectors utilizing Current State Analysis.	10/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 2 Compensation and Benefit Analysis	On Hold	Complete the compensation and benefit analysis/assessment engaging all partners; HR Departments fully engaged. The analysis will contain current salaries and benefits allowing for comparison analysis between current and future to determine how staff hiring and redeployment will be impacted.	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 3 Complete Report	On Hold	Complete report about changes to the compensation and benefit structure and its impact on DSRIP implementation;	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		report noted changes to job roles, functions and locations across all projects to workforce committee, and PPS governance							
Task 4 Compensation and Benefit Package	On Hold	Develop compensation and benefit package for retrained, redeployed staff impacted by DSRIP project implementation and for new hires whose services and skills will be instrumental in achieving DSRIP goals.	10/01/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #5 Develop training strategy.	On Hold	Finalized training strategy, signed off by PPS workforce governance body.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	NO
Task 1 Identify Training Needs	On Hold	Complete itemized description of Current State training needs; the needs are specific, delineating the skills, knowledge and attitudes that staff will require to be successful in the implementation of the DSRIP projects.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 2 Create Inventory of Skills	On Hold	Complete itemized inventory of the skills and competencies of the current workforce in eah sector and compare to the skills and competencies required of the future worksforce. Draft a training strategy to bridge the gaps. Identify training materials, champions and/or vendor(s) to provide staff re-training and training.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 3 Training Strategy	On Hold	Complete comprehensive training strategy; the strategy will include philosophical underpinnings, goals and objectives, measurable outcomes, methodology and deployment plan, activities, evaluation, and program process and procedures. The strategy will also include: plan to identify/collect/create/test and evaluate training materials that are culturally competent and language specific; and a Communications Strategy to disseminate information about changes to the workforce, training opportunities and the overall initiative.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 4 Approve Strategy	On Hold	Acquire approvals for training strategy by PPS governing body.	01/01/2016	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

1. Staff reaction to change:
Fear of job loss and security,
Resistance to-new roles
Resistance to new processes and procedures
Resistance to training offerings
Nurses in particular have expressed through the public comment process that some of their functions may be delegated to new staff; leading to dissatisfaction in nursing ranks and loss of positions to less trained, income and motivation. Unaddressed, fear and resistance to new changes can have a negative impact on implementation of DSRIP and the timely completion of milestones.
The major strategy to mitigate this factor is the development and implementation of a comprehensive Communication Plan that includes sections specifically targeting the workforce in conjunction with other partners. The communication Plan will call for the creation of forums including members of the Workforce, to provide information and voice concerns about DSRIP, its philosophical underpinnings and practices.

2. Workforce shortages and recruitment challenges: (especially for some of the more specialized positions) may represent important challenges to the PPS. The successful recruitment and hiring of critical members of the talent pool is critical to a successful project implementation. In order to mitigate this factor the WC will carefully analyze and advise on the final workforce budget to insure that it includes adequate funding for recruitment.

3. New hires: the major challenge consists in putting together a mission conscious, driven, culturally competent, effective team, in a relatively short period of time. Lack of team cohesion can have a negative impact on the work of the PPS. The PPSs commitment to hire from within the community is a positive mitigating factor for this challenge.

4. Systems change: change tends to transpire over a longer period of time than that prescribed for DSRIP implementation much is being asked of all partners in a PPS at an accelerated pace. This impacts workforce as it impacts employees at all levels and may require the hiring of new, and re-training and/or redeployment of staff thus creating some difficulties and variations in the workflows and dynamics of practices. Clearly PPS success depends on high levels of cooperation and performance from all partners. The fact that all of the physicians in the network are organized through IPAs and ACOs and are familiar with operations within a capitated environment is a very favorable and mitigating factor.

5. Overall risks: the implementation of the DSRIP projects will most definitely require change in the workflows and dynamics of the primary care practices. This may require hiring of new staff since these offices are already functioning at staff capacity. This presents a dual challenge because the offices may also be operating at capacity in their physical space and they have no budget for new staff salaries and benefits. The PPS plans to mitigate this challenge by streamlining as many processes as possible and creating incentives that help the providers and provide support with the hiring process.

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IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

Instructions :

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

The PPS understands that in order to launch a functional and effective Integrated Delivery System, it must recruit, train, re-train, and deploy a workforce that can perform and deliver on program goals and objectives. In this manner all Work streams are interdependent on the Workforce Work stream. More specifically:

• The workforce strategy will incorporate input from the CBOs and PAC for cultural competency to ensure training materials are prepared and seminars are conducted in a culturally competent and linguistically sensitive manner.
• The workforce strategy will work closely with the clinical integration workgroups of each project to ensure appropriate staffing levels are maintained and in the appropriate categories to efficiently complete the project goals, i.e. employing sufficient care managers to manage high risk patients to minimize hospital readmissions.
• The workforce transformation will rely heavily on the success of an efficient IT system throughout the PPS to maintain current health records, to streamline the workload and efforts of the workforce, utilizing the information to manage Medicaid beneficiary health. In return the Workforce Work stream will work with the IT Work stream to insure that IT has sufficient staffing to build and manage new systems and that the IT staff is properly trained to insure efficiency and compliance.
• To achieve the workforce transformation, the Governance, Finance and Workforce must work closely together to ensure adequate financial resources to execute key workforce activities.

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IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
PPS Governing body	Ramon Tallaj, Md, Chairman	Review and approval of all reports, training strategy, budget, consultants and vendors/oversight and approval
Workforce lead	Moises Perez-Martinez, Director of Workforce, Community and Government Relations	Complete workstream milestones/manage workflow
Member, Workforce Committee	Howard Tuchman, HR Specialist NSLIJ; Sheila Garvey, HR Medisys	Current/Future State Report for Lenox and Forest Hills Hospitals and Medisys hospital system/ Fully populated template Execution of implementation plan
Member Workforce Committee	Liz Webb, Director of HR, ACP	Current/Future Status Report for physicians and PPS sectors/ Fully populated template Execution of implementation plan
Member Workforce Committee	Josephine Wu, Dir Operations, PPS Representative	Current/Future Status Report for physicians and PPS sectors/ Fully populated template Execution of implementation plan
Member Workforce Committee	Joanne King, East Harlem HELP, CBO Representative	Current/Future Status Report for CBOs/ Fully populated template Execution of implementation plan
Labor representative	Florence Wong, Deputy Director of the 1199 Training and Employment Funds	Workforce training Strategy/provide administrative services in execution of strategy
Workforce Budget/staff analyst	Wallace Lau, CFO, ACP	Workforce budget/Provide data and report on staffing pattern and Workforce budget
Staff support to workstream	Manager, Workforce Workstream	Complete workstream milestones/assist in workflow task completion, coordinate training
IT/Project Lead	John Dionisio, Director of IT, ACP	System and process to track and evaluate workforce workstream activities and outcomes/Oversight of the development and implementation of IT systems to monitor DSRIP impact on workforce

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IPQR Module 11.7 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Liz Webb	ACP HR Lead	Assemble workforce/HR functions
Howard Tuchman, NSLIJ	HR Specialist	Assemble workforce/HR functions
Sheila Garvey, Vice President Human Resources at Jamaica Hospital Medical Center/Medisys	HR Lead	Assemble workforce/HR functions
Oscar Fukilman, MD	Corinthian and Balance Medical IPAs	Support data collection/oversight
Joanne King, Director EH HELP	CBO Representative	Support data collection/oversight
Rebecca Gordon, Chief Collective Bargaining , NSLIJ	Labor Liaison	Agreement with 1199TEF/labor negotiations
External Stakeholders		
Sen. Gustavo Rivera, Member Health Committee	Legislative oversight in NYS Senate	PPS support/legislator
Helen Schaub, Director of Policy and Government Affairs, 1199 SEIU	Labor representative	Advise on workstream development and implementation/participate on Steering Committee
Faith Based Organizations	Assist in engaging community resources for cultural competency	Provide input/streamline communication with community workforce
Marianela Nunez, MA, and Sobeira Guillen, MSW training consultants	Training consultant	Provide training curriculum

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IPQR Module 11.8 - IT Expectations

Instructions :

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

A shared IT infrastructure will have a transformative impact on the workforce by making fundamental changes to patterns of communication and the basic manner in which the PPS partners approach the work. Specifically, the development of an IT infrastructure is essential to the development and implementation of the Integrated Delivery System. In turn, the effective interaction of the workforce through the system represents a major transformation of the workforce.

A robust HIE platform will increase the PPS' analytics capabilities. The HIE platform will provide a wide range of information streams related to the workforce. Some of these may include but not be limited to:

Expansion/reduction of workforce
Number of displaced workers
Number of new hires
Number of workers re-trained and re-deployed
Retention efforts
Geographic distribution of the workforce

The IT infrastructure will make it possible for the PPS to more efficiently focus on "hotspots" and facilitate staff deployment.

Succession planning and staff development will also be enhanced through the deployment of a shared IT infrastructure.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

The overall success of the Workforce organizational work stream will be measured on the basis of the following 3 criteria:

1. Documented ability to mitigate negative impacts on the workforce as a result of DSRIP
Maintaining the integrity of the labor force is a high priority for the PPS. Careful assessment and planning related to workforce will be critical to achieving this goal. The PPS will maintain complete records of number of employees displaced, re-trained and re-deployed in "real time" through enhanced analytics capabilities. Once a common IT infrastructure is established, the PPS will be able to analyze and report on progress on

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demand.

2. Successful recruitment, hire, training and deployment of new staff
The task of assembling a new staff will be critical to the success of the PPS. While the process of skills training can take place over a longer time frame, it is absolutely essential that the newly hired workforce fully understand and accept the mission, vision and philosophical underpinnings of DSRIP and the PPS. The PPS will administer surveys and questionnaires to measure the level of understanding and acceptance of the PPS' vision and mission and report on the outcome of these interventions.

3. Increased readiness to engage in value based contracting
Increased readiness to engage in value based contracting is an important goal of the PPS. The PPS and WC will draft a roadmap to meet this goal and report regularly on its implementation.

Reporting on progress against PPS targets will be systematic and continuous. The following steps will be followed in order to insure timely and accurate reporting on progress against targets:
Targets set across all PPS sectors
PPS Workforce Lead meets with key staff to review targets/anticipate challenges
Supervisory staff responsible for specific target area is responsible for developing a schedule of activities aimed at successful attainment of desired targets
Staff report on activities against targets bi-monthly
Corrective plan of action is drafted for targets determined to be behind schedule
Review of progress on corrective plan of action is conducted weekly
Monthly reports are generated and shared across the PPS with members of the WC and other pertinent members
Timely reports are prepared and presented to NYSDOH within the specified schedule. Progress reports will track: the number of employees trained, the number of employees retrained and redeployed, and the number of new hires.

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IPQR Module 11.10 - Staff Impact

Instructions :

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

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

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

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

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

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

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IPQR Module 11.11 - IA Monitoring:

Instructions :

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

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

Instructions :

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

1. IDS: ACP providers have been independent and the change to an IDS (IDS) might be a risk. We intend to educate a shared vision at all levels, from the Board down to participating providers and their staff. Provider buy-in will be developed through communication and education and on-going support to will be available. Sufficient budget dollars and workforce are critical to support the IT plans for and IDS. Funds flow will also motivate providers to change practice and workflow behaviors. Additionally, while many use cases have been projected, there could be scenarios that may not have been considered. The PPS will have back-up processes in place in case of a gap in the system, including manual work-arounds and web-based portals to securely send information with providers and care managers.
2. Budget: the wide scope requires a budget that can accomodate project implementation. Funds flow allocated toward building an IDS needs to be sufficient to cover the 'must-have' items. The PPS has a contingency line item in the budget that can acommodate potential costs not currently specifically budgeted.
3. Patient compliance and engagement: the PPS will need to find creative ways to ensure patient compliance and engagement. Current efforts by the providers and health plans have some impact, but still find that many patients do not seek care in clinically appropriate settings. The PPS has to work closely with all providers to ensure proper identification and engagement of patients are effective. Literature suggests that high levels of patient satisfaction leads to improved patient engagement. The PPS can assess and identify barriers that prevent patient satisfaction to assist with improvement of patient engagement.
4. Provider Culture: providers' ability and time to document a disease-specific, personalized care plan for each patient with an at-risk chronic illness could be a potential risk. This will require additional time with the patients to provide, not only, a written care plan and sufficient documentation, but also educating the patient on the importance of plan compliance. ACP plans to mitigate by providing support at the provider level. This support includes care teams that are culturally competent, which include other practitioners, BH providers, pharmacists, nurse educators and care managers. In addition, ACP has developed electronic versions of disease specific care plans that can be personalized within the EMR to provide trackable documentation. This will assist providers in billing for complex care management services for their additional time and effort per patient. Also, given the unique structure of our PPS that spans more than 2,000 physicians and community based providers, communication and information sharing could be a challenge. ACP is reaching out and discussing possible collaborations with all of the hospitals in ACP's catchment area and those which any ACP attributed patient may receive services.
5. PCMH Certification Requirement: an additional risk is PCP compliance with level 3 PCMH certification. As referenced in the second risk, ACP has developed templates within the EMR minimizing the time that it will take providers to complete.
6. Physician/Patient Relationship: many cultures are biased towards going to the emergency department (ED) for care, as it is seen as more convenient and immediately responsive than a PCP visit. Our PPS will provide education and awareness to emphasize connecting to a PCP and working with community organization partners to expand outreach into the ethnic groups represented in the population. Additionally, the ED triage process will include a team of Patient Navigators available to every patient to satisfy project requirements such as ensuring appointments prior to ED discharge, with the intent of connecting to a PCP and reduce avoidable ED visits.

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IPQR Module 2.a.i.2 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 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.	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Develop participation agreement language for each provider type requiring mandatory participation in the ACP Integrated Delivery System. Assess feasibility of developing borough-level organization regarding communication and large-scale implementation, such as integrated delivery system or the population health projects. ACP PPS is community-based and community-physician led. A majority of our community partners have been included because the Medicaid patients assigned to our physicians use the physicians within the network. Thus, these providers have been included in large scale within ACP's network and will continue to assist the providers and the patients in providing appropriate medical care and social support. Additionally, most community-based provider types (including Mental Health, Substance Abuse and Social Supports) will be included in the PPS network.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2 Establish a Project 2.a.i. Leadership Team with roles and responsibilities to take a leadership role on this project. Project	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
will be co-led by the Director of Clinical Operations, Lidia Virgil and Director of IT, John Dionisio. Team will include expertise from all areas (IT and IT security, Clinical Operations, Workforce [Moises Perez], Compliance (Tom Hoering), amongst others) and will require support from providers and staff. Additionally, because of the heavy dependencies on IT, support from physician EHR vendors will also be key in the success of the creation of an integrated delivery system.									
Task 3 Develop Project 2.a.i. Roadmap with timeline which would include flexibility to be reviewed and updated at least annually and ability to explore adding potential partners (including social service organizations/CBOs). The roadmap will incorporate any IT assessments derived from the IT milestones, determine future state and propose solutions to achieve the target state. The roadmap will consider the connectivity needs of all provider types (including Mental Health, Substance Abuse and Social Supports) to create an integrated solution.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Finalize (including ACP Board approval) Project 2.a.i. Roadmap with timeline, including timeline for provider contracting with partners within the organization.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Identify key Health Homes and ACO partners to create workgroup (include discussions with relevant committees, for	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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example, IT Committee on integrating IT capabilities)									
Task 2. Develop matrix of core capabilities of partnering Health Homes and ACOs, including provider services, IT assessments, etc. Matrix, as part of roadmap, should identify strengths and weaknesses of existing systems and processes. IT integration solution shall incorporate existing system strengths (strong network, structured communication processes, referral tracking, care management capabilities, strategies regarding patient compliance) and complement weaknesses (manual workarounds, workflow gaps, resource gaps, IT shortfalls).	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Develop strategy for partnering with Health Home and ACO population management systems and capabilities that incorporates roadmap and matrix developments. Leverage existing effective processes and understand components that are needed to scale processes to broader network. Introduce centralized processes that the PPS will manage to assist with expanding scale.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Finalize strategy and incorporate into Project 2.a.i Roadmap with timeline, with flexibility to be reviewed and updated at least annually. Flexibility of design will allow for continuous system improvement that will maximize impact within network.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
followed.									
Task PPS trains staff on IDS protocols and processes.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1 ACP needs to understand the population it serves in order to ensure appropriate care is provided. Categorize ACP attributed beneficiaries into stratified risk groups using a common model (e.g., HCC, John Hopkins, 3M) and identify priority disease conditions for each category (based on State provided data on ACP's attributed beneficiaries, claims data from MAPP, Salient, IPAs' / ACOs' data from MCOs and Medicare, and providers' EHRs / medical record data). The data can come from variety of sources, including State, MCO and physician EHR. Stratification then allows PPS to understand and develop specific interventions that can positively impact patients (High-risk patients will require extensive, coordinated care. Moderate-risk patients will require some care, but as important, should received proper care that keeps the patient at moderate-risk status or potentially drop to low-risk status if possible [goal is to prevent patient from entering high-risk status]. Low-risk patients will need to receive preventive care to ensure that this cohort remain low-risk and does not move up to moderate or high-risk status.). Stratification algorithm based on common models can be developed/formalized in concert with PPS analytics team that is being assembled.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2 Review and adopt clinical protocols from PPS's selected Domain 2,3 and 4 projects for priority disease conditions among ACP attributed members. Protocols outline care steps that will guide physicians to ensure appropriate health care is provided. If required, appropriate community and social supports will be included in care plans to ensure member receives holistic (or whole-person) care. ACP's leadership and network safety-net community partners understands the population that it serves often require more than medical care. Supports from CBOs, Mental Health/Substance Abuse organizations, post-acute care such as Skilled Nursing Facilities and some Nursing Homes, long-term care providers and public health services are key to	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
ensuring care is provided and maintained in between physician visits.									
Task 3 Develop a directory of available resources (includes typical and atypical providers types). Typical providers types are those who provide medical care such as physicians, clinics, hospitals, behavioral health, substance abuse, etc. Atypical providers are those who address socio-economic factors such as housing agencies, community-based organizations and social services. These resources can provide services based on the clinical protocols for care coordination needs and address gaps that are delivered in appropriate settings.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4 Identify additional provider type gaps based on resource directory and take necessary action to fill those gaps looking at all provider types, such as reaching out to CBOs and providers for participation in ACP. Network will continue to evolve as ACP's members' needs change. It is important to ensure patients needs are continually monitored to ensure appropriate care is given. Stratification step (step 1) will be completed periodically to ensure that the appropriate provider types are available.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5 Develop system to engage patients with PPS using variety of methods such as patient navigators, community health workers, or access to patient portals that allow for a systematic way of communication between PPS, its partners and the patient requiring care. Currently, many agencies conduct patient outreach, however there is opportunity to improve patient engagement. ACP will assess creative yet practical ways to engage with patients including electronic outreach (smart phone apps, telephonic/text reminders) and community-based outreach (outreach to caregivers). PPS will also utilize patient satisfaction survey tools to assess ways to improve patient satisfaction (high levels of patient satisfaction has shown high levels of compliance) to improve patient compliance.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 6 Finalize ACP care coordination strategy to include structure,	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
roles, responsibilities, services, policies and procedures, with linkages to other work streams as detailed in the ACP projects implementation plan. ACP plans to centralize its care coordination function (while leveraging existing effective care coordination processes within its network) where referral management and patient engagement strategies are key roles. Care coordination is a core function within an integrated delivery system - sufficient resources, tools and support, workflows and strategies will be included in the final roadmap. Support from other workstreams such as IT (ensure technology enables communication and the coordination), clinical operations (ensure protocols provide appropriate evidence-based care pathways for physicians to follow) , workforce (appropriate training and re-training is provided so that the process is followed), and practitioner engagement (ensure physicians understand their roles with the provision of care) will assist with effective care coordination.									
Task 7 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely to patients. Processes will be developed to track progress, including providing feedback that allow for process improvement. Metrics to assist with measuring timely delivery of services include: Referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 8 Begin implementation of ACP projects implementation plan which includes tracking that patients receive appropriate support and care. This can be performed in various ways, such as understanding care gaps and outreaching to patients to close. PCMH, a major component of this project, specifically outlines various clinical care process improvement requirements involving immunization, preventive care and chronic or acute care measures.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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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.									
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Establish work plans with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feed into HIE.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4 Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 7 Develop final plan for sharing health information among clinical partners by DY3.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.	Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Survey and group all participating safety net providers into level of readiness.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Refine priority of clinical issues from CNAs to include specific priorities by geographic areas and ensure alignment between projects undertaken.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Create a database for program planning (expand on data collected as part of our CNA)	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Review adopted clinical protocols, care guidelines, established performance measures and metrics for each clinical area with participating safety net providers to monitor progress in managing population health.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4 Develop a population health database that is able to drill down at all levels using data from various sources, such as EHRs (with bi-directionally capable HIE)	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5 Perform data analyses to identify priority clinical issues and establish registries.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6 Develop process to access individual provider EHRs and use registries to understand disease-specific drivers that will lead to population health initiatives.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7 Complete workforce assessment for care management capabilities among all participating safety net providers, including	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
staff skills and resources required to manage priority at risk populations in each geographic area.									
Task 8 Develop workforce training / re-training / support staff assignment to mitigate workforce gaps.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9 Deploy staff support at provider level to train providers and staff on how to use and apply information learned from registries; how to establish care guidelines, develop disease pathways and inform on metrics for monitoring progress in managing population health.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Survey and group all participating providers (safety net and non safety net) into level of readiness.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Develop plan, timelines, and assign resources for each level of readiness.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Clinical governance committee approves partner assessment results and PCMH roadmap.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
with potential PCMH vendors (external).									
Task 5 Implement plan.	Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task 6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Project	N/A	In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 1 Complete value-based payment arrangement assessment at each IPA (each IPAs to review its respective list of existing contracts with MCOs and other payers and identify and explore opportunities for value-based payment arrangements). Leverage activities from Financial Sustainability workstream regarding contracting with MCOs regarding VBP. Lastly, assessment results will determine best options to take for establishing VBP contracts.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Establish ACP Financial Sustainability/VBP committee to explore ACP contracts with MCOs and other payers on value-based payment arrangements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Develop ACP value-based payment roadmap. Roadmap, similar to New York State Roadmap for Medicaid Payment Reform ('A Path toward Value Based Payment'), cohorts need to be established to understand which methodologies will be the most appropriate. All Care for Total Population Option may not be the optimal option initially, especially for high risk subpopulations or populations where bundling might be a better option, however it is expected to achieve level 3 VBP regardless VBP type. Currently, the IPAs are under a capitated/FFS with risk sharing (All Care for Total Population Level 2). The IPAs are familiar with this concept and with appropriate reporting (to	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
emphasize focus on outcomes) and support, the groups can effectively transition into Level 3. For other providers, the other VBP options will be discussed directly and recommendations presented as to how each provider type (BH, SUD, SNF, Hospital, Health Home, CBOs, etc) will be compensated.									
Task 4 Approve ACP value-based payment roadmap.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Project	N/A	In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1 Identify MCOs.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Establish committee.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Develop committee charter, goals, meeting schedules, etc.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4 Conduct monthly meeting with MCOs to discuss utilization trends, performance issues, and payment reform issues.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5 Initiate VBP transition plan including interim steps and complete by DSRIP timelines.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Project	N/A	In Progress	10/01/2015	12/31/2017	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		In Progress	07/01/2017	12/31/2017	07/01/2017	12/31/2017	12/31/2017	DY3 Q3
Task 1 Establish committee (committee will include expertise from other workstreams such as Clinical Programs (Lidia Virgil), Compliance (Tom Hoering), Finance (Wallace Lau), IT (John	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Dionisio). The IPA leadership (Ramon Tallaj, MD, Henry Chen, MD, Emilio VIllegas, MD) will play a role with physician engagement. Other providers such as hospitals (NSLIJ and Medisys Hospital System) will also represent. The PAC will also be engaged as they represent the overall network (including post-acute care providers, CBOs, BH and SUD, etc). Lastly, the MCOs will need to be part of this committee or play an advisory role to ensure the VBP levels and options are operationally feasible and to establish appropriate timelines based on DSRIP commitments.									
Task 2 Develop committee charter, goals, meeting schedules, work plan, deliverables and timelines.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3 Approve a roadmap for transition towards value-based payment by aligning provider compensation to patient outcomes. Performance reporting is a major component to VBP. MCOs will need to provide adequate data and reporting to tie practitioner performance to patient outcomes.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 4 Conduct meeting(s) with safety net providers to obtain comments, ideas, suggestions, obstacles, issues, possible solutions. VBP approach is key with a large network with a wide spectrum of provider types. MCO contracting will need to ensure VBP approach is appropriate.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5 Conduct meeting(s) with MCOs to ensure needs are addressed, such as appropriate contracting language, data exchange and benchmark info that will determine goals.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6 Develop potential models that adhere to roadmap guidelines that are appropriate to cost categories (total population care vs sub-population care vs bundling, etc). The various physician groups within ACP has familiarity with risk contracting and capitation models that could help facilitate the transition to VBP.	Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and finalize contracting	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
points and terms with MCOs.									
Task 8 Implement plan and establish monthly/quarterly meetings to ensure VBP models are successful and understand the drivers of success. If VBP models are unsuccessful, develop targeted initiatives that impact cost drivers, taking both unit cost and utilization metrics of the various cost categories into consideration.	Project		In Progress	01/01/2017	12/31/2017	01/01/2017	12/31/2017	12/31/2017	DY3 Q3
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Project	N/A	In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	Project		In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 1 Establish patient engagement committee.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Establish committee charter, work plan, milestones, timelines.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Develop an IDS patient engagement plan that is culturally appropriate. Plan should also include assessment of health literacy of patients so initiatives can be developed to address potential health literacy barriers. Socio-economic factors should be considered so that medical needs become a priority for patients. Use of community health workers, peers, advocacy groups, families and caregivers can supplement traditional outreach methods (such as mailers or telephonic outreach). These groups are typically from the same community, culturally competent and can be trained to have high levels or health literacy to convey messages effectively. In addition, community-based organizations have grassroots level reach to members and can assist with engagement with the providers within the PPS. Lastly, plan should include assessment of patient satisfaction. As previously mentioned, high levels of patient satisfaction can lead to higher levels of patient engagement.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task	Project		In Progress	01/01/2016	03/01/2017	01/01/2016	03/01/2017	03/31/2017	DY2 Q4

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4 Develop potential models and design, including development of workforce requirements,such as training or re-training community health workers, peers, advocacy groups and CBOs. Because ACP is a physician-led, community-based PPS, it has wide array of provider types that it can leverage to engage patients in very culturally appropriate ways. Aligning these resources will assist with effective outreach and patient engagement.									
Task 5 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely and patients remain engaged. Processes and reporting will be developed to track progress, including providing feedback that allow for process improvement, referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6 Implement pilot programs that target high-risk neighborhoods or areas with high concentrations of attributed patients. High-risk areas would focus on the conditions related to ACP's selected projects. Culturally competent Community Health Workers and other staff as well as Community Based Organization partners would work in tandem to ensure use of resources are efficient and effective. Pilot programs would include education, patient engagement and navigation of healthcare delivery system.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7 Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and deploy resources to target areas.	Project		In Progress	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 8 Develop tool to track activities and establish key performance indicators and success metrics that tie to overall goals of the projects.	Project		In Progress	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1

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Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.										
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
Task 1 Develop participation agreement language for each provider type requiring mandatory participation in the ACP Integrated Delivery System. Assess feasibility of developing borough-level organization regarding communication and large-scale implementation, such as integrated delivery system or the population health projects. ACP PPS is community-based and community-physician led. A majority of our community partners have been included because the Medicaid patients assigned to our physicians use the physicians within the network. Thus, these providers have been included in large scale within ACP's network and will continue to assist the providers and the patients in providing appropriate medical care and social support. Additionally, most community-based provider types (including Mental Health, Substance Abuse and Social Supports) will be included in the PPS network.										
Task 2 Establish a Project 2.a.i. Leadership Team with roles and responsibilities to take a leadership role on this project. Project will be co-led by the Director of Clinical Operations, Lidia Virgil and Director of IT, John Dionisio. Team will include expertise from all areas (IT and IT security, Clinical Operations, Workforce [Moises Perez], Compliance (Tom Hoering), amongst others) and will require support from providers and staff. Additionally, because of the heavy dependencies on IT, support from physician EHR vendors will also be key in the success of the creation of an integrated delivery system.										
Task 3 Develop Project 2.a.i. Roadmap with timeline which would include flexibility to be reviewed and updated at least annually and ability to explore adding potential partners (including social service organizations/CBOs). The roadmap will incorporate any IT assessments derived from the IT milestones, determine future state and propose solutions to achieve the target state. The										

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roadmap will consider the connectivity needs of all provider types (including Mental Health, Substance Abuse and Social Supports) to create an integrated solution.										
Task 4 Finalize (including ACP Board approval) Project 2.a.i. Roadmap with timeline, including timeline for provider contracting with partners within the organization.										
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.										
Task PPS produces a list of participating HHs and ACOs.										
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task 1 Identify key Health Homes and ACO partners to create workgroup (include discussions with relevant committees, for example, IT Committee on integrating IT capabilities)										
Task 2. Develop matrix of core capabilities of partnering Health Homes and ACOs, including provider services, IT assessments, etc. Matrix, as part of roadmap, should identify strengths and weaknesses of existing systems and processes. IT integration solution shall incorporate existing system strengths (strong network, structured communication processes, referral tracking, care management capabilities, strategies regarding patient compliance) and complement weaknesses (manual workarounds, workflow gaps, resource gaps, IT shortfalls).										
Task 3. Develop strategy for partnering with Health Home and ACO population management systems and capabilities that incorporates roadmap and matrix developments. Leverage existing effective processes and understand components that are needed to scale processes to broader network. Introduce centralized processes that the PPS will manage to assist with expanding scale.										
Task 4 Finalize strategy and incorporate into Project 2.a.i Roadmap with timeline, with flexibility to be reviewed and updated at least										

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annually. Flexibility of design will allow for continuous system improvement that will maximize impact within network.										
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.										
Task Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task 1 ACP needs to understand the population it serves in order to ensure appropriate care is provided. Categorize ACP attributed beneficiaries into stratified risk groups using a common model (e.g., HCC, John Hopkins, 3M) and identify priority disease conditions for each category (based on State provided data on ACP's attributed beneficiaries, claims data from MAPP, Salient, IPAs' / ACOs' data from MCOs and Medicare, and providers' EHRs / medical record data). The data can come from variety of sources, including State, MCO and physician EHR. Stratification then allows PPS to understand and develop specific interventions that can positively impact patients (High-risk patients will require extensive, coordinated care. Moderate-risk patients will require some care, but as important, should received proper care that keeps the patient at moderate-risk status or potentially drop to low-risk status if possible [goal is to prevent patient from entering high-risk status]. Low-risk patients will need to receive preventive care to ensure that this cohort remain low-risk and does not move up to moderate or high-risk status.). Stratification algorithm based on common models can be developed/formalized in concert with PPS analytics team that is being assembled.										
Task 2 Review and adopt clinical protocols from PPS's selected Domain 2,3 and 4 projects for priority disease conditions among ACP attributed members. Protocols outline care steps that will										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
guide physicians to ensure appropriate health care is provided. If required, appropriate community and social supports will be included in care plans to ensure member receives holistic (or whole-person) care. ACP's leadership and network safety-net community partners understands the population that it serves often require more than medical care. Supports from CBOs, Mental Health/Substance Abuse organizations, post-acute care such as Skilled Nursing Facilities and some Nursing Homes, long-term care providers and public health services are key to ensuring care is provided and maintained in between physician visits.										
Task 3 Develop a directory of available resources (includes typical and atypical providers types). Typical providers types are those who provide medical care such as physicians, clinics, hospitals, behavioral health, substance abuse, etc. Atypical providers are those who address socio-economic factors such as housing agencies, community-based organizations and social services. These resources can provide services based on the clinical protocols for care coordination needs and address gaps that are delivered in appropriate settings.										
Task 4 Identify additional provider type gaps based on resource directory and take necessary action to fill those gaps looking at all provider types, such as reaching out to CBOs and providers for participation in ACP. Network will continue to evolve as ACP's members' needs change. It is important to ensure patients needs are continually monitored to ensure appropriate care is given. Stratification step (step 1) will be completed periodically to ensure that the appropriate provider types are available.										
Task 5 Develop system to engage patients with PPS using variety of methods such as patient navigators, community health workers, or access to patient portals that allow for a systematic way of communication between PPS, its partners and the patient requiring care. Currently, many agencies conduct patient outreach, however there is opportunity to improve patient engagement. ACP will assess creative yet practical ways to engage with patients including electronic outreach (smart phone apps, telephonic/text reminders) and community-based outreach (outreach to caregivers). PPS will also utilize patient satisfaction survey tools to assess ways to improve patient satisfaction (high levels of patient satisfaction has shown high levels of compliance) to improve patient compliance.										

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Task 6 Finalize ACP care coordination strategy to include structure, roles, responsibilities, services, policies and procedures, with linkages to other work streams as detailed in the ACP projects implementation plan. ACP plans to centralize its care coordination function (while leveraging existing effective care coordination processes within its network) where referral management and patient engagement strategies are key roles. Care coordination is a core function within an integrated delivery system - sufficient resources, tools and support, workflows and strategies will be included in the final roadmap. Support from other workstreams such as IT (ensure technology enables communication and the coordination), clinical operations (ensure protocols provide appropriate evidence-based care pathways for physicians to follow) , workforce (appropriate training and re-training is provided so that the process is followed), and practitioner engagement (ensure physicians understand their roles with the provision of care) will assist with effective care coordination.										
Task 7 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely to patients. Processes will be developed to track progress, including providing feedback that allow for process improvement. Metrics to assist with measuring timely delivery of services include: Referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.										
Task 8 Begin implementation of ACP projects implementation plan which includes tracking that patients receive appropriate support and care. This can be performed in various ways, such as understanding care gaps and outreaching to patients to close. PCMH, a major component of this project, specifically outlines various clinical care process improvement requirements involving immunization, preventive care and chronic or acute care measures.										
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.										

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Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	75	150	262
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	50	100	174
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	2	3	5
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	10	20	34
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	4	7	12
Task PPS uses alerts and secure messaging functionality.										
Task 1 Establish work plans with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR.										
Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feed into HIE.										
Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.										
Task 4 Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.										
Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.										
Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.										
Task 7 Develop final plan for sharing health information among clinical partners by DY3.										

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Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	75	150	262
Task 1 Survey and group all participating safety net providers into level of readiness.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).										
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.										
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.										
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 1 Refine priority of clinical issues from CNAs to include specific priorities by geographic areas and ensure alignment between										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
projects undertaken.										
Task 2 Create a database for program planning (expand on data collected as part of our CNA)										
Task 3 Review adopted clinical protocols, care guidelines, established performance measures and metrics for each clinical area with participating safety net providers to monitor progress in managing population health.										
Task 4 Develop a population health database that is able to drill down at all levels using data from various sources, such as EHRs (with bi-directionally capable HIE)										
Task 5 Perform data analyses to identify priority clinical issues and establish registries.										
Task 6 Develop process to access individual provider EHRs and use registries to understand disease-specific drivers that will lead to population health initiatives.										
Task 7 Complete workforce assessment for care management capabilities among all participating safety net providers, including staff skills and resources required to manage priority at risk populations in each geographic area.										
Task 8 Develop workforce training / re-training / support staff assignment to mitigate workforce gaps.										
Task 9 Deploy staff support at provider level to train providers and staff on how to use and apply information learned from registries; how to establish care guidelines, develop disease pathways and inform on metrics for monitoring progress in managing population health.										
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.										
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.										

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

DSRIP Implementation Plan Project

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	91	181	316
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task 1 Survey and group all participating providers (safety net and non safety net) into level of readiness.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness.										
Task 3 Clinical governance committee approves partner assessment results and PCMH roadmap.										
Task 4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).										
Task 5 Implement plan.										
Task 6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task 1 Complete value-based payment arrangement assessment at each IPA (each IPAs to review its respective list of existing contracts with MCOs and other payers and identify and explore opportunities for value-based payment arrangements). Leverage activities from Financial Sustainability workstream regarding contracting with MCOs regarding VBP. Lastly, assessment results will determine best options to take for establishing VBP contracts.										
Task 2 Establish ACP Financial Sustainability/VBP committee to explore ACP contracts with MCOs and other payers on value-based payment arrangements.										

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DSRIP Implementation Plan Project

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 3 Develop ACP value-based payment roadmap. Roadmap, similar to New York State Roadmap for Medicaid Payment Reform ('A Path toward Value Based Payment'), cohorts need to be established to understand which methodologies will be the most appropriate. All Care for Total Population Option may not be the optimal option initially, especially for high risk subpopulations or populations where bundling might be a better option, however it is expected to achieve level 3 VBP regardless VBP type. Currently, the IPAs are under a capitated/FFS with risk sharing (All Care for Total Population Level 2). The IPAs are familiar with this concept and with appropriate reporting (to emphasize focus on outcomes) and support, the groups can effectively transition into Level 3. For other providers, the other VBP options will be discussed directly and recommendations presented as to how each provider type (BH, SUD, SNF, Hospital, Health Home, CBOs, etc) will be compensated.										
Task 4 Approve ACP value-based payment roadmap.										
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.										
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.										
Task 1 Identify MCOs.										
Task 2 Establish committee.										
Task 3 Develop committee charter, goals, meeting schedules, etc.										
Task 4 Conduct monthly meeting with MCOs to discuss utilization trends, performance issues, and payment reform issues.										
Task 5 Initiate VBP transition plan including interim steps and complete by DSRIP timelines.										
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.										
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.										
Task 1 Establish committee (committee will include expertise from other workstreams such as Clinical Programs (Lidia Virgil), Compliance (Tom Hoering), Finance (Wallace Lau), IT (John Dionisio). The IPA leadership (Ramon Tallaj, MD, Henry Chen, MD, Emilio VIllegas, MD) will play a role with physician engagement. Other providers such as hospitals (NSLIJ and Medisys Hospital System) will also represent. The PAC will also be engaged as they represent the overall network (including post-acute care providers, CBOs, BH and SUD, etc). Lastly, the MCOs will need to be part of this committee or play an advisory role to ensure the VBP levels and options are operationally feasible and to establish appropriate timelines based on DSRIP commitments.										
Task 2 Develop committee charter, goals, meeting schedules, work plan, deliverables and timelines.										
Task 3 Approve a roadmap for transition towards value-based payment by aligning provider compensation to patient outcomes. Performance reporting is a major component to VBP. MCOs will need to provide adequate data and reporting to tie practitioner performance to patient outcomes.										
Task 4 Conduct meeting(s) with safety net providers to obtain comments, ideas, suggestions, obstacles, issues, possible solutions. VBP approach is key with a large network with a wide spectrum of provider types. MCO contracting will need to ensure VBP approach is appropriate.										
Task 5 Conduct meeting(s) with MCOs to ensure needs are addressed, such as appropriate contracting language, data exchange and benchmark info that will determine goals.										
Task 6 Develop potential models that adhere to roadmap guidelines that are appropriate to cost categories (total population care vs sub-population care vs bundling, etc). The various physician groups within ACP has familiarity with risk contracting and capitation models that could help facilitate the transition to VBP.										
Task 7Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and finalize contracting										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
points and terms with MCOs.										
Task 8 Implement plan and establish monthly/quarterly meetings to ensure VBP models are successful and understand the drivers of success. If VBP models are unsuccessful, develop targeted initiatives that impact cost drivers, taking both unit cost and utilization metrics of the various cost categories into consideration.										
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.										
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										
Task 1 Establish patient engagement committee.										
Task 2 Establish committee charter, work plan, milestones, timelines.										
Task 3 Develop an IDS patient engagement plan that is culturally appropriate. Plan should also include assessment of health literacy of patients so initiatives can be developed to address potential health literacy barriers. Socio-economic factors should be considered so that medical needs become a priority for patients. Use of community health workers, peers, advocacy groups, families and caregivers can supplement traditional outreach methods (such as mailers or telephonic outreach). These groups are typically from the same community, culturally competent and can be trained to have high levels or health literacy to convey messages effectively. In addition, community-based organizations have grassroots level reach to members and can assist with engagement with the providers within the PPS. Lastly, plan should include assessment of patient satisfaction. As previously mentioned, high levels of patient satisfaction can lead to higher levels of patient engagement.										
Task 4 Develop potential models and design, including development of workforce requirements,such as training or re-training community health workers, peers, advocacy groups and CBOs. Because ACP is a physician-led, community-based PPS, it has wide array of provider types that it can leverage to engage patients in very culturally appropriate ways. Aligning these										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
resources will assist with effective outreach and patient engagement.										
Task 5 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely and patients remain engaged. Processes and reporting will be developed to track progress, including providing feedback that allow for process improvement, referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.										
Task 6 Implement pilot programs that target high-risk neighborhoods or areas with high concentrations of attributed patients. High-risk areas would focus on the conditions related to ACP's selected projects. Culturally competent Community Health Workers and other staff as well as Community Based Organization partners would work in tandem to ensure use of resources are efficient and effective. Pilot programs would include education, patient engagement and navigation of healthcare delivery system.										
Task 7 Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and deploy resources to target areas.										
Task 8 Develop tool to track activities and establish key performance indicators and success metrics that tie to overall goals of the projects.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.										
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
Task 1 Develop participation agreement language for each provider type requiring mandatory participation in the ACP Integrated										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Delivery System. Assess feasibility of developing borough-level organization regarding communication and large-scale implementation, such as integrated delivery system or the population health projects. ACP PPS is community-based and community-physician led. A majority of our community partners have been included because the Medicaid patients assigned to our physicians use the physicians within the network. Thus, these providers have been included in large scale within ACP's network and will continue to assist the providers and the patients in providing appropriate medical care and social support. Additionally, most community-based provider types (including Mental Health, Substance Abuse and Social Supports) will be included in the PPS network.										
Task 2 Establish a Project 2.a.i. Leadership Team with roles and responsibilities to take a leadership role on this project. Project will be co-led by the Director of Clinical Operations, Lidia Virgil and Director of IT, John Dionisio. Team will include expertise from all areas (IT and IT security, Clinical Operations, Workforce [Moises Perez], Compliance (Tom Hoering), amongst others) and will require support from providers and staff. Additionally, because of the heavy dependencies on IT, support from physician EHR vendors will also be key in the success of the creation of an integrated delivery system.										
Task 3 Develop Project 2.a.i. Roadmap with timeline which would include flexibility to be reviewed and updated at least annually and ability to explore adding potential partners (including social service organizations/CBOs). The roadmap will incorporate any IT assessments derived from the IT milestones, determine future state and propose solutions to achieve the target state. The roadmap will consider the connectivity needs of all provider types (including Mental Health, Substance Abuse and Social Supports) to create an integrated solution.										
Task 4 Finalize (including ACP Board approval) Project 2.a.i. Roadmap with timeline, including timeline for provider contracting with partners within the organization.										
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.										
Task PPS produces a list of participating HHs and ACOs.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task 1 Identify key Health Homes and ACO partners to create workgroup (include discussions with relevant committees, for example, IT Committee on integrating IT capabilities)										
Task 2. Develop matrix of core capabilities of partnering Health Homes and ACOs, including provider services, IT assessments, etc. Matrix, as part of roadmap, should identify strengths and weaknesses of existing systems and processes. IT integration solution shall incorporate existing system strengths (strong network, structured communication processes, referral tracking, care management capabilities, strategies regarding patient compliance) and complement weaknesses (manual workarounds, workflow gaps, resource gaps, IT shortfalls).										
Task 3. Develop strategy for partnering with Health Home and ACO population management systems and capabilities that incorporates roadmap and matrix developments. Leverage existing effective processes and understand components that are needed to scale processes to broader network. Introduce centralized processes that the PPS will manage to assist with expanding scale.										
Task 4 Finalize strategy and incorporate into Project 2.a.i Roadmap with timeline, with flexibility to be reviewed and updated at least annually. Flexibility of design will allow for continuous system improvement that will maximize impact within network.										
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.										
Task Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task 1 ACP needs to understand the population it serves in order to ensure appropriate care is provided. Categorize ACP attributed beneficiaries into stratified risk groups using a common model (e.g., HCC, John Hopkins, 3M) and identify priority disease conditions for each category (based on State provided data on ACP's attributed beneficiaries, claims data from MAPP, Salient, IPAs' / ACOs' data from MCOs and Medicare, and providers' EHRs / medical record data). The data can come from variety of sources, including State, MCO and physician EHR. Stratification then allows PPS to understand and develop specific interventions that can positively impact patients (High-risk patients will require extensive, coordinated care. Moderate-risk patients will require some care, but as important, should received proper care that keeps the patient at moderate-risk status or potentially drop to low-risk status if possible [goal is to prevent patient from entering high-risk status]. Low-risk patients will need to receive preventive care to ensure that this cohort remain low-risk and does not move up to moderate or high-risk status.). Stratification algorithm based on common models can be developed/formalized in concert with PPS analytics team that is being assembled.										
Task 2 Review and adopt clinical protocols from PPS's selected Domain 2,3 and 4 projects for priority disease conditions among ACP attributed members. Protocols outline care steps that will guide physicians to ensure appropriate health care is provided. If required, appropriate community and social supports will be included in care plans to ensure member receives holistic (or whole-person) care. ACP's leadership and network safety-net community partners understands the population that it serves often require more than medical care. Supports from CBOs, Mental Health/Substance Abuse organizations, post-acute care such as Skilled Nursing Facilities and some Nursing Homes, long-term care providers and public health services are key to ensuring care is provided and maintained in between physician visits.										
Task 3 Develop a directory of available resources (includes typical and										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
atypical providers types). Typical providers types are those who provide medical care such as physicians, clinics, hospitals, behavioral health, substance abuse, etc. Atypical providers are those who address socio-economic factors such as housing agencies, community-based organizations and social services. These resources can provide services based on the clinical protocols for care coordination needs and address gaps that are delivered in appropriate settings.										
Task 4 Identify additional provider type gaps based on resource directory and take necessary action to fill those gaps looking at all provider types, such as reaching out to CBOs and providers for participation in ACP. Network will continue to evolve as ACP's members' needs change. It is important to ensure patients needs are continually monitored to ensure appropriate care is given. Stratification step (step 1) will be completed periodically to ensure that the appropriate provider types are available.										
Task 5 Develop system to engage patients with PPS using variety of methods such as patient navigators, community health workers, or access to patient portals that allow for a systematic way of communication between PPS, its partners and the patient requiring care. Currently, many agencies conduct patient outreach, however there is opportunity to improve patient engagement. ACP will assess creative yet practical ways to engage with patients including electronic outreach (smart phone apps, telephonic/text reminders) and community-based outreach (outreach to caregivers). PPS will also utilize patient satisfaction survey tools to assess ways to improve patient satisfaction (high levels of patient satisfaction has shown high levels of compliance) to improve patient compliance.										
Task 6 Finalize ACP care coordination strategy to include structure, roles, responsibilities, services, policies and procedures, with linkages to other work streams as detailed in the ACP projects implementation plan. ACP plans to centralize its care coordination function (while leveraging existing effective care coordination processes within its network) where referral management and patient engagement strategies are key roles. Care coordination is a core function within an integrated delivery system - sufficient resources, tools and support, workflows and strategies will be included in the final roadmap. Support from other workstreams such as IT (ensure technology enables communication and the coordination), clinical operations (ensure										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
protocols provide appropriate evidence-based care pathways for physicians to follow) , workforce (appropriate training and re-training is provided so that the process is followed), and practitioner engagement (ensure physicians understand their roles with the provision of care) will assist with effective care coordination.										
Task 7 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely to patients. Processes will be developed to track progress, including providing feedback that allow for process improvement. Metrics to assist with measuring timely delivery of services include: Referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.										
Task 8 Begin implementation of ACP projects implementation plan which includes tracking that patients receive appropriate support and care. This can be performed in various ways, such as understanding care gaps and outreaching to patients to close. PCMH, a major component of this project, specifically outlines various clinical care process improvement requirements involving immunization, preventive care and chronic or acute care measures.										
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	524	748	748	748	748	748	748	748	748	748
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	348	496	496	496	496	496	496	496	496	496
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	10	13	13	13	13	13	13	13	13	13
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	68	96	96	96	96	96	96	96	96	96
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	23	32	32	32	32	32	32	32	32	32

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
requirements.										
Task PPS uses alerts and secure messaging functionality.										
Task 1 Establish work plans with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR.										
Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feed into HIE.										
Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.										
Task 4 Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.										
Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.										
Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.										
Task 7 Develop final plan for sharing health information among clinical partners by DY3.										
Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	524	748	748	748	748	748	748	748	748	748
Task 1 Survey and group all participating safety net providers into level of readiness.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).										
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.										
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.										
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 1 Refine priority of clinical issues from CNAs to include specific priorities by geographic areas and ensure alignment between projects undertaken.										
Task 2 Create a database for program planning (expand on data collected as part of our CNA)										
Task 3 Review adopted clinical protocols, care guidelines, established performance measures and metrics for each clinical area with participating safety net providers to monitor progress in managing population health.										
Task 4 Develop a population health database that is able to drill down at all levels using data from various sources, such as EHRs (with bi-directionally capable HIE)										

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Task 5 Perform data analyses to identify priority clinical issues and establish registries.										
Task 6 Develop process to access individual provider EHRs and use registries to understand disease-specific drivers that will lead to population health initiatives.										
Task 7 Complete workforce assessment for care management capabilities among all participating safety net providers, including staff skills and resources required to manage priority at risk populations in each geographic area.										
Task 8 Develop workforce training / re-training / support staff assignment to mitigate workforce gaps.										
Task 9 Deploy staff support at provider level to train providers and staff on how to use and apply information learned from registries; how to establish care guidelines, develop disease pathways and inform on metrics for monitoring progress in managing population health.										
Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.										
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.										
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	632	902	902	902	902	902	902	902	902	902
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task 1 Survey and group all participating providers (safety net and non safety net) into level of readiness.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness.										
Task 3 Clinical governance committee approves partner assessment										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
results and PCMH roadmap.										
Task 4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).										
Task 5 Implement plan.										
Task 6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task 1 Complete value-based payment arrangement assessment at each IPA (each IPAs to review its respective list of existing contracts with MCOs and other payers and identify and explore opportunities for value-based payment arrangements). Leverage activities from Financial Sustainability workstream regarding contracting with MCOs regarding VBP. Lastly, assessment results will determine best options to take for establishing VBP contracts.										
Task 2 Establish ACP Financial Sustainability/VBP committee to explore ACP contracts with MCOs and other payers on value-based payment arrangements.										
Task 3 Develop ACP value-based payment roadmap. Roadmap, similar to New York State Roadmap for Medicaid Payment Reform ('A Path toward Value Based Payment'), cohorts need to be established to understand which methodologies will be the most appropriate. All Care for Total Population Option may not be the optimal option initially, especially for high risk subpopulations or populations where bundling might be a better option, however it is expected to achieve level 3 VBP regardless VBP type. Currently, the IPAs are under a capitated/FFS with risk sharing (All Care for Total Population Level 2). The IPAs are familiar with this concept and with appropriate reporting (to emphasize focus on outcomes) and support, the groups can effectively transition into Level 3. For other providers, the other										

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VBP options will be discussed directly and recommendations presented as to how each provider type (BH, SUD, SNF, Hospital, Health Home, CBOs, etc) will be compensated.										
Task 4 Approve ACP value-based payment roadmap.										
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.										
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.										
Task 1 Identify MCOs.										
Task 2 Establish committee.										
Task 3 Develop committee charter, goals, meeting schedules, etc.										
Task 4 Conduct monthly meeting with MCOs to discuss utilization trends, performance issues, and payment reform issues.										
Task 5 Initiate VBP transition plan including interim steps and complete by DSRIP timelines.										
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.										
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.										
Task 1 Establish committee (committee will include expertise from other workstreams such as Clinical Programs (Lidia Virgil), Compliance (Tom Hoering), Finance (Wallace Lau), IT (John Dionisio). The IPA leadership (Ramon Tallaj, MD, Henry Chen, MD, Emilio VIllegas, MD) will play a role with physician engagement. Other providers such as hospitals (NSLIJ and Medisys Hospital System) will also represent. The PAC will also be engaged as they represent the overall network (including post-acute care providers, CBOs, BH and SUD, etc). Lastly, the MCOs will need to be part of this committee or play an advisory role to ensure the VBP levels and options are operationally										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
feasible and to establish appropriate timelines based on DSRIP commitments.										
Task 2 Develop committee charter, goals, meeting schedules, work plan, deliverables and timelines.										
Task 3 Approve a roadmap for transition towards value-based payment by aligning provider compensation to patient outcomes. Performance reporting is a major component to VBP. MCOs will need to provide adequate data and reporting to tie practitioner performance to patient outcomes.										
Task 4 Conduct meeting(s) with safety net providers to obtain comments, ideas, suggestions, obstacles, issues, possible solutions. VBP approach is key with a large network with a wide spectrum of provider types. MCO contracting will need to ensure VBP approach is appropriate.										
Task 5 Conduct meeting(s) with MCOs to ensure needs are addressed, such as appropriate contracting language, data exchange and benchmark info that will determine goals.										
Task 6 Develop potential models that adhere to roadmap guidelines that are appropriate to cost categories (total population care vs sub-population care vs bundling, etc). The various physician groups within ACP has familiarity with risk contracting and capitation models that could help facilitate the transition to VBP.										
Task 7Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and finalize contracting points and terms with MCOs.										
Task 8 Implement plan and establish monthly/quarterly meetings to ensure VBP models are successful and understand the drivers of success. If VBP models are unsuccessful, develop targeted initiatives that impact cost drivers, taking both unit cost and utilization metrics of the various cost categories into consideration.										
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.										
Task Community health workers and community-based organizations										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
utilized in IDS for outreach and navigation activities.										
Task 1 Establish patient engagement committee.										
Task 2 Establish committee charter, work plan, milestones, timelines.										
Task 3 Develop an IDS patient engagement plan that is culturally appropriate. Plan should also include assessment of health literacy of patients so initiatives can be developed to address potential health literacy barriers. Socio-economic factors should be considered so that medical needs become a priority for patients. Use of community health workers, peers, advocacy groups, families and caregivers can supplement traditional outreach methods (such as mailers or telephonic outreach). These groups are typically from the same community, culturally competent and can be trained to have high levels or health literacy to convey messages effectively. In addition, community-based organizations have grassroots level reach to members and can assist with engagement with the providers within the PPS. Lastly, plan should include assessment of patient satisfaction. As previously mentioned, high levels of patient satisfaction can lead to higher levels of patient engagement.										
Task 4 Develop potential models and design, including development of workforce requirements,such as training or re-training community health workers, peers, advocacy groups and CBOs. Because ACP is a physician-led, community-based PPS, it has wide array of provider types that it can leverage to engage patients in very culturally appropriate ways. Aligning these resources will assist with effective outreach and patient engagement.										
Task 5 Develop tracking and monitoring capabilities (audit function) to ensure that services are delivered timely and patients remain engaged. Processes and reporting will be developed to track progress, including providing feedback that allow for process improvement, referral close times and rates, monitor global outreach rates, general patient visit rates (ie reduce non-utilizing patient rates), quality care gap hit rates, patient satisfaction, etc.										
Task 6 Implement pilot programs that target high-risk neighborhoods or areas with high concentrations of attributed patients. High-risk areas would focus on the conditions related to ACP's selected projects. Culturally competent Community Health Workers and										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
other staff as well as Community Based Organization partners would work in tandem to ensure use of resources are efficient and effective. Pilot programs would include education, patient engagement and navigation of healthcare delivery system.										
Task 7 Present models to Board and acquire approval. Ensure stakeholder buy-in where appropriate and deploy resources to target areas.										
Task 8 Develop tool to track activities and establish key performance indicators and success metrics that tie to overall goals of the projects.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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.	jd593813	Other	25_PMDL2003_1_3_20160202192927_2ai_1.3-1.4_2.2-2.3_4.4_IT_Roadmap.pdf	IT Roadmap	02/02/2016 07:29 PM
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.	jd593813	Other	25_PMDL2003_1_3_20160203131540_2ai_11.1-11.2_Patient_Engagement_Committee.pdf	Patient Engagement Committee Charter	02/03/2016 01:15 PM
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	jd593813	Other	25_PMDL2003_1_3_20160202193113_2ai_1.3-1.4_2.2-2.3_4.4_IT_Roadmap.pdf	IT Roadmap	02/02/2016 07:31 PM
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.	jd593813	Other	25_PMDL2003_1_3_20160202193254_2ai_1.3-1.4_2.2-2.3_4.4_IT_Roadmap.pdf	IT Roadmap	02/02/2016 07:32 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	jd593813	Other	25_PMDL2003_1_3_20160203000006_2ai_6.1-6.2_Community_Engagement_Plan.pdf	Community engagement plan as a result of CNA	02/03/2016 12:00 AM
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	jd593813	Meeting Materials	25_PMDL2003_1_3_20160202194737_2ai_9.1-9.2_MCO_Meeting_Agenda.pdf	MCO Meeting Agenda	02/02/2016 07:47 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	
Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	
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.	
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.	5.1 ACP Providers have been surveyed and categorized as PCMH-Certified EMR's, PCMH non-certified EMR's, and paper providers. Each level will indicate a level of readiness for PCMH transformation. 5.2 ACP has developed different strategies for implementing providers in each PCMH category as explained above. Those plans will establish the different timelines needed for the different needs each provider will have for PCMH transformation. 5.3 ACP has established communications to ACP safety net providers that establish key PCMH designated personnel, ACP/NCQA/PCMH Vendor resources, etc.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries,	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
for all participating safety net providers.	
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.	7.1 ACP Providers have been surveyed and categorized as non-PCMH certified, current PCMH certified, and paper providers. Each category will indicate a level of readiness for PCMH transformation/actualization. 7.2 ACP has partnered with vendors that will serve as resources for practice transformations by following the ACP Implementation plan for each provider category type.
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	9.1 MCOs and contacts developed with MCOs. 9.2 MCO meeting occurred on 1/14/2016, agenda is included as an attachment..
Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	
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.	

Milestone Review Status

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

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IPQR Module 2.a.i.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 2.a.i.4 - IA Monitoring

Instructions :

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Project 2.a.iii – Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services

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

Instructions :

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

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

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	153,818

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
30,763	46,145	100.00%	0	30.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
jd593813	Rosters	25_PMDL2215_1_3_20160203155906_HHR_Patient_Engagement.xlsx	Patient Engagement File	02/03/2016 03:59 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

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

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 5 Ensure that Care Plans are created, printed and explained in the language of the patients being served and implemented in a culturally appropriate manner.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6 Develop ACP processes and procedures included in protocols to include more stringent care coordination emulating health homes at the Primary Care office with PCMH level standards of care.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7 Creation of Central Care Management/Care coordination teams at the level of health Homes through ACP's intense back office/Care Coordination department to provide more centralized, efficient integrated care.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Leverage ACP's strong PCP network to establish and enhance relationships between partner hospitals and primary care providers for open communication and accessibility.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Utilize physician engagement teams, IPA groups, and physician champions to engage all PCPs in ACP's network in the participation of DSRIP and educate on the importance of advanced primary care and achievement of NCQA 2014 PCMH certification.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Contract with PCMH certified professionals that will assist the practices in attaining 2014 NCQA PCMH accreditation by year 3.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4 Develop tracking tool linked to physician database to understand progress for each physician undergoing PCMH	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
certification.									
Task 5 Develop remediation plan with steps for assisting physicians that require additional support in achieving 2014 PCMH level 3 accreditation.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #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.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Case Management / Health Home	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Work with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4 Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.									
Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 7 Develop final plan for sharing health information among clinical partners by DY3.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.	Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 9 Develop tracking tool linked to physician database to understand physician data sharing activities on health information exchange/RHIO/SHIN-NY.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 10 Periodically review physicians (more frequently at the beginning) to ensure data is being shared and that bi-directional activities are evident.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1 Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 5 Develop tracking tool linked to physician database to monitor EHR system use. Additionally, physician process adherence will be tracked (methodologies should follow developed protocols and how-to's).	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6 Develop remediation plan with steps for assisting physicians that require additional support in appropriate use of EHR systems to support PCMH requirements.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Develop and implement algorithm to be used to stratify and identify target patients. Algorithm to include specific chronic disease codes to understand at-risk population.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

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

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DSRIP Implementation Plan Project

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
orders are fulfilled and the patient receives any needed care.									
Task 3 Hire and train Care Managers in the back office to also be readily available to the patients and reach out and be manage their care ie. Medications, counsel, etc. thus ensuring that the patient has what he/she needs for management of disease and increased quality of life.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Case Management / Health Home	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Develop protocols in which each entities roles are delineated. Protocol should clearly establish the primary care provider's responsibility, care plan implementation, as well as health home eligibility and the roles of the health home.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 ACP will leverage its partner Health Homes and establish clear partnerships with the HH and PCPs through its regional Care Teams. ACP's care Teams are comprised of partners within a given region and they include providers of all types including HHs. Health Homes will be linked and partnered with the PCPs within their regions. The HHs and PCPs will collaborate in accordance with the set protocols and processes.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 ACP has a vast number of patients, due to this, ACP will work with the HHs in the network to incorporate best practices and processes into a back office/care coordination team that will provide additional, enhanced care coordination and management.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
4 Primary Care Provider's role shall be as per the protocol to provide evidence based disease management, implementing a comprehensive care plan for specific disease management. PCP office will work with Care Coordination team in Health Home model care coordination									
Task 5 Health Homes' role shall be to provide guidance, assistance and support in the implementation of a Health Home model of Care Coordination as well as provide Health Home services as needed for patients eligible to receive care under the Medicaid Health Home eligibility criteria.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #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).	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Case Management / Health Home	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Establish relationships and partnership with Behavioral Health, OASAS, OMH entities and engage in a service agreement. Engage these entities in all regions and counties in which ACP serves.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Establish relationships with local government, social and specialty services such as SPOAs, agencies for the developmentally disabled to coordinate and provide needed services to patients.	Project		In Progress	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Include identified entities in Care Teams, PAC, Clinical Quality	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Committees to help develop, coordinate and disseminate best practices, protocols, etc and provide higher quality service.									
Task 4 Liaise and form partnerships between these entities and the PCP especially in areas where these services have been lacking and patient are going without needed care and services.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5 ACP will implement a referral process by which all referrals are entered and submitted via the EMR and go through an HIE. ACP partners' and associated providers' information shall be uploaded and prompted to the PCP or other referrer as a referral database so that referrals can be made to the needed service provider or agency that has made a commitment to tend to ACP patients in the specified timeframe and manner.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6 All referrals shall go through to the ACP central data repository and shall be stored and documented for monitoring and adherence to procedure.	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7 Referrals going through ACP's HIE are picked up and are monitored by the ACP central care coordinators to ensure completeness and attainment of services in a timely and efficient manner and for further care coordination.	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task PPS has included social services agencies in development of	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
risk reduction and care practice guidelines.									
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 ACP will develop and implement best practices in care management and care coordination in conjunction with Health Home partners and develop evidence based protocols for disease management.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Develop uniform Comprehensive Care plans which will include disease self management techniques and will also include risk reduction activities, recognizing of warning signs and family education and support materials. The Care plans will be in different languages to be given to the patient's of ACP in their appropriate language. Furthermore, the Care plans will be consistent with the Cultural sensitivities of the population/patient being served.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Develop Evidence based protocols for chronic diseases with the help of Primary care physicians, specialists physicians and associations such as JNC-8, American Lung Association, etc.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 4 Disseminate protocols to all providers within the PPS through physician engagement meetings, physician engagement teams and IPAs.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5 With the help of the IPAs, physician champions, the PAC, and other committees, obtain physician "buy-in" support and commitment on implementation of evidence based ACP protocols.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 6 Draft partner agreements sand obtain signatures from partners acknowledging participation and adherence to ACP protocols, processes and procedures.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7 Establish partnerships and agreements with social services agencies to assist in the provision of needed services and	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
implement risk reduction, +which can include protective services, shelter, housing, food, etc.									

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.										
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs										
Task 1 Develop protocol for identification of Patients at risk for progressing to Health Home eligibility. Protocol shall contain definitions, and intervention through PCPs, Care Managers and Coordinators/Health Homes, and specialists										
Task 2 Develop a health home at risk intervention model with prescribed implementation of Comprehensive Care plans for each patient with a chronic progressive disease. Care plans will be uniform and distributed throughout the PPS provider partners through the provider engagement teams. Short cuts and in-putting and monitoring of these within provider EMRs will be developed and trained by the team.										
Task 3 Disseminate protocol to ACP PCPs to treat patients in accordance with evidence based protocols to include referrals to specialist and social services as necessary.										
Task 4 Develop Care Plan to include patient self-management techniques, disease specific education, how to recognize triggers, remove hazards and avoid complications.										
Task 5 Ensure that Care Plans are created, printed and explained in the language of the patients being served and implemented in a culturally appropriate manner.										
Task 6 Develop ACP processes and procedures included in protocols to include more stringent care coordination emulating health										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
homes at the Primary Care office with PCMH level standards of care.										
Task 7 Creation of Central Care Management/Care coordination teams at the level of health Homes through ACP's intense back office/Care Coordination department to provide more centralized, efficient integrated care.										
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	0	0	0	0	0	0	0	91	181	316
Task 1 Leverage ACP's strong PCP network to establish and enhance relationships between partner hospitals and primary care providers for open communication and accessibility.										
Task 2 Utilize physician engagement teams, IPA groups, and physician champions to engage all PCPs in ACP's network in the participation of DSRIP and educate on the importance of advanced primary care and achievement of NCQA 2014 PCMH certification.										
Task 3 Contract with PCMH certified professionals that will assist the practices in attaining 2014 NCQA PCMH accreditation by year 3.										
Task 4 Develop tracking tool linked to physician database to understand progress for each physician undergoing PCMH certification.										
Task 5 Develop remediation plan with steps for assisting physicians that require additional support in achieving 2014 PCMH level 3 accreditation.										
Milestone #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.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	0	0	0	0	0	0	0	75	150	262

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
requirements.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	50	100	174
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	1	2	3
Task PPS uses alerts and secure messaging functionality.										
Task 1 Work with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.										
Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.										
Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.										
Task 4 Develop other interim solutions for sharing health information among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.										
Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.										
Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.										
Task 7 Develop final plan for sharing health information among clinical partners by DY3.										
Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 9 Develop tracking tool linked to physician database to understand physician data sharing activities on health information exchange/RHIO/SHIN-NY.										
Task 10 Periodically review physicians (more frequently at the beginning) to ensure data is being shared and that bi-directional activities are evident.										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	75	150	262
Task 1 Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).										
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.										
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.										
Task 5 Develop tracking tool linked to physician database to monitor EHR system use. Additionally, physician process adherence will be tracked (methodologies should follow developed protocols and how-to's).										
Task 6 Develop remediation plan with steps for assisting physicians that require additional support in appropriate use of EHR										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
systems to support PCMH requirements.										
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 1 Develop and implement algorithm to be used to stratify and identify target patients. Algorithm to include specific chronic disease codes to understand at-risk population.										
Task 2 Develop a strategy with timeline to be used to obtain significant data from EMR registries or from practice management systems. Data should include in all cases patient demographics in addition to the specified data used in the algorithm.										
Task 3 Identify data analytics staff or practice champion to perform the data pulls at the specified times.										
Task 4 Perform comparative analysis using data pulls from ACP central data repository and other platforms such as Salient and MCOs to validate and verify data and implement targeted and population health strategies.										
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.										
Task Procedures to engage at-risk patients with care management plan instituted.										
Task 1 Develop comprehensive care plans to distribute throughout the PPS with disease specific education and instruction on self-management, risk reduction, identification and elimination of triggers. The comprehensive care plans also include home assessments and family/caregiver intervention. The Care Plans will be presented to the patient with appropriate training at the point of care by the Primary Care Provider.										
Task 2 Create a back office protocol that consists of outreach staff, care coordinators that will remain in contact with the patients,										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
establish a rapport with the patient and caregiver/family to ensure that communication gaps and patient discomfort levels are resolved. The number of calls and follow ups per week/month will vary depending on patient's health status and patient's health literacy rates. Care Coordinators will ensure that appointments are made and kept, transportation is made available whenever necessary, orders are fulfilled and the patient receives any needed care.										
Task 3 Hire and train Care Managers in the back office to also be readily available to the patients and reach out and be manage their care ie. Medications, counsel, etc. thus ensuring that the patient has what he/she needs for management of disease and increased quality of life.										
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	0	0	0	0	0	0	91	181	316
Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	0	0	0	0	0	0	1	2	4
Task 1 Develop protocols in which each entities roles are delineated. Protocol should clearly establish the primary care provider's responsibility, care plan implementation, as well as health home eligibility and the roles of the health home.										
Task 2 ACP will leverage its partner Health Homes and establish clear partnerships with the HH and PCPs through its regional Care Teams. ACP's care Teams are comprised of partners within a given region and they include providers of all types including HHs. Health Homes will be linked and partnered with the PCPs within their regions. The HHs and PCPs will collaborate in accordance with the set protocols and processes.										
Task 3 ACP has a vast number of patients, due to this, ACP will work with the HHs in the network to incorporate best practices and processes into a back office/care coordination team that will provide additional, enhanced care coordination and management.										
Task 4 Primary Care Provider's role shall be as per the protocol to										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
provide evidence based disease management, implementing a comprehensive care plan for specific disease management. PCP office will work with Care Coordination team in Health Home model care coordination										
Task 5 Health Homes' role shall be to provide guidance, assistance and support in the implementation of a Health Home model of Care Coordination as well as provide Health Home services as needed for patients eligible to receive care under the Medicaid Health Home eligibility criteria.										
Milestone #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).										
Task PPS has established partnerships to medical, behavioral health, and social services.	0	0	0	0	0	0	0	91	181	316
Task PPS has established partnerships to medical, behavioral health, and social services.	0	0	0	0	0	0	0	1	2	4
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task 1 Establish relationships and partnership with Behavioral Health, OASAS, OMH entities and engage in a service agreement. Engage these entities in all regions and counties in which ACP serves.										
Task 2 Establish relationships with local government, social and specialty services such as SPOAs, agencies for the developmentally disabled to coordinate and provide needed services to patients.										
Task 3 Include identified entities in Care Teams, PAC, Clinical Quality Committees to help develop, coordinate and disseminate best practices, protocols, etc and provide higher quality service.										
Task 4 Liaise and form partnerships between these entities and the PCP especially in areas where these services have been lacking and patient are going without needed care and services.										
Task 5 ACP will implement a referral process by which all referrals are										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
entered and submitted via the EMR and go through an HIE. ACP partners' and associated providers' information shall be uploaded and prompted to the PCP or other referrer as a referral database so that referrals can be made to the needed service provider or agency that has made a commitment to tend to ACP patients in the specified timeframe and manner.										
Task 6 All referrals shall go through to the ACP central data repository and shall be stored and documented for monitoring and adherence to procedure.										
Task 7 Referrals going through ACP's HIE are picked up and are monitored by the ACP central care coordinators to ensure completeness and attainment of services in a timely and efficient manner and for further care coordination.										
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.										
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.										
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.										
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.										
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.										
Task 1 ACP will develop and implement best practices in care management and care coordination in conjunction with Health Home partners and develop evidence based protocols for disease management.										
Task 2 Develop uniform Comprehensive Care plans which will include disease self management techniques and will also include risk reduction activities, recognizing of warning signs and family education and support materials. The Care plans will be in different languages to be given to the patient's of ACP in their										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
appropriate language. Furthermore, the Care plans will be consistent with the Cultural sensitivities of the population/patient being served.										
Task 3 Develop Evidence based protocols for chronic diseases with the help of Primary care physicians, specialists physicians and associations such as JNC-8, American Lung Association, etc.										
Task 4 Disseminate protocols to all providers within the PPS through physician engagement meetings, physician engagement teams and IPAs.										
Task 5 With the help of the IPAs, physician champions, the PAC, and other committees, obtain physician "buy-in" support and commitment on implementation of evidence based ACP protocols.										
Task 6 Draft partner agreements sand obtain signatures from partners acknowledging participation and adherence to ACP protocols, processes and procedures.										
Task 7 Establish partnerships and agreements with social services agencies to assist in the provision of needed services and implement risk reduction, +which can include protective services, shelter, housing, food, etc.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.										
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs										
Task 1 Develop protocol for identification of Patients at risk for progressing to Health Home eligibility. Protocol shall contain definitions, and intervention through PCPs, Care Managers and Coordinators/Health Homes, and specialists										
Task 2 Develop a health home at risk intervention model with										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
prescribed implementation of Comprehensive Care plans for each patient with a chronic progressive disease. Care plans will be uniform and distributed throughout the PPS provider partners through the provider engagement teams. Short cuts and in-putting and monitoring of these within provider EMRs will be developed and trained by the team.										
Task 3 Disseminate protocol to ACP PCPs to treat patients in accordance with evidence based protocols to include referrals to specialist and social services as necessary.										
Task 4 Develop Care Plan to include patient self-management techniques, disease specific education, how to recognize triggers, remove hazards and avoid complications.										
Task 5 Ensure that Care Plans are created, printed and explained in the language of the patients being served and implemented in a culturally appropriate manner.										
Task 6 Develop ACP processes and procedures included in protocols to include more stringent care coordination emulating health homes at the Primary Care office with PCMH level standards of care.										
Task 7 Creation of Central Care Management/Care coordination teams at the level of health Homes through ACP's intense back office/Care Coordination department to provide more centralized, efficient integrated care.										
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	632	902	902	902	902	902	902	902	902	902
Task 1 Leverage ACP's strong PCP network to establish and enhance relationships between partner hospitals and primary care providers for open communication and accessibility.										
Task 2 Utilize physician engagement teams, IPA groups, and physician champions to engage all PCPs in ACP's network in the participation of DSRIP and educate on the importance of										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
advanced primary care and achievement of NCQA 2014 PCMH certification.										
Task 3 Contract with PCMH certified professionals that will assist the practices in attaining 2014 NCQA PCMH accreditation by year 3.										
Task 4 Develop tracking tool linked to physician database to understand progress for each physician undergoing PCMH certification.										
Task 5 Develop remediation plan with steps for assisting physicians that require additional support in achieving 2014 PCMH level 3 accreditation.										
Milestone #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.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	524	748	748	748	748	748	748	748	748	748
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	348	496	496	496	496	496	496	496	496	496
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	6	8	8	8	8	8	8	8	8	8
Task PPS uses alerts and secure messaging functionality.										
Task 1 Work with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.										
Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.										
Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.										
Task 4 Develop other interim solutions for sharing health information										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
among clinical partners using direct exchange, alerts, and patient record lookup. Determine other needs or enhancements based on IT/integration gap analyses.										
Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.										
Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.										
Task 7 Develop final plan for sharing health information among clinical partners by DY3.										
Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.										
Task 9 Develop tracking tool linked to physician database to understand physician data sharing activities on health information exchange/RHIO/SHIN-NY.										
Task 10 Periodically review physicians (more frequently at the beginning) to ensure data is being shared and that bi-directional activities are evident.										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	524	748	748	748	748	748	748	748	748	748
Task 1 Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.										
Task 2 Develop plan, timelines, and assign resources for each level of										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).										
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.										
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.										
Task 5 Develop tracking tool linked to physician database to monitor EHR system use. Additionally, physician process adherence will be tracked (methodologies should follow developed protocols and how-to's).										
Task 6 Develop remediation plan with steps for assisting physicians that require additional support in appropriate use of EHR systems to support PCMH requirements.										
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 1 Develop and implement algorithm to be used to stratify and identify target patients. Algorithm to include specific chronic disease codes to understand at-risk population.										
Task 2 Develop a strategy with timeline to be used to obtain significant data from EMR registries or from practice management systems. Data should include in all cases patient demographics in addition to the specified data used in the algorithm.										
Task 3 Identify data analytics staff or practice champion to perform the data pulls at the specified times.										
Task 4 Perform comparative analysis using data pulls from ACP central data repository and other platforms such as Salient and MCOs to validate and verify data and implement targeted and										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
population health strategies.										
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.										
Task Procedures to engage at-risk patients with care management plan instituted.										
Task 1 Develop comprehensive care plans to distribute throughout the PPS with disease specific education and instruction on self-management, risk reduction, identification and elimination of triggers. The comprehensive care plans also include home assessments and family/caregiver intervention. The Care Plans will be presented to the patient with appropriate training at the point of care by the Primary Care Provider.										
Task 2 Create a back office protocol that consists of outreach staff, care coordinators that will remain in contact with the patients, establish a rapport with the patient and caregiver/family to ensure that communication gaps and patient discomfort levels are resolved. The number of calls and follow ups per week/month will vary depending on patient's health status and patient's health literacy rates. Care Coordinators will ensure that appointments are made and kept, transportation is made available whenever necessary, orders are fulfilled and the patient receives any needed care.										
Task 3 Hire and train Care Managers in the back office to also be readily available to the patients and reach out and be manage their care ie. Medications, counsel, etc. thus ensuring that the patient has what he/she needs for management of disease and increased quality of life.										
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.	632	902	902	902	902	902	902	902	902	902
Task Each identified PCP establish partnerships with the local Health Home for care management services.	7	9	9	9	9	9	9	9	9	9

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 1 Develop protocols in which each entities roles are delineated. Protocol should clearly establish the primary care provider's responsibility, care plan implementation, as well as health home eligibility and the roles of the health home.										
Task 2 ACP will leverage its partner Health Homes and establish clear partnerships with the HH and PCPs through its regional Care Teams. ACP's care Teams are comprised of partners within a given region and they include providers of all types including HHs. Health Homes will be linked and partnered with the PCPs within their regions. The HHs and PCPs will collaborate in accordance with the set protocols and processes.										
Task 3 ACP has a vast number of patients, due to this, ACP will work with the HHs in the network to incorporate best practices and processes into a back office/care coordination team that will provide additional, enhanced care coordination and management.										
Task 4 Primary Care Provider's role shall be as per the protocol to provide evidence based disease management, implementing a comprehensive care plan for specific disease management. PCP office will work with Care Coordination team in Health Home model care coordination										
Task 5 Health Homes' role shall be to provide guidance, assistance and support in the implementation of a Health Home model of Care Coordination as well as provide Health Home services as needed for patients eligible to receive care under the Medicaid Health Home eligibility criteria.										
Milestone #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).										
Task PPS has established partnerships to medical, behavioral health, and social services.	632	902	902	902	902	902	902	902	902	902
Task PPS has established partnerships to medical, behavioral health, and social services.	7	9	9	9	9	9	9	9	9	9
Task PPS uses EHRs and HIE system to facilitate and document										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
partnerships with needed services.										
Task 1 Establish relationships and partnership with Behavioral Health, OASAS, OMH entities and engage in a service agreement. Engage these entities in all regions and counties in which ACP serves.										
Task 2 Establish relationships with local government, social and specialty services such as SPOAs, agencies for the developmentally disabled to coordinate and provide needed services to patients.										
Task 3 Include identified entities in Care Teams, PAC, Clinical Quality Committees to help develop, coordinate and disseminate best practices, protocols, etc and provide higher quality service.										
Task 4 Liaise and form partnerships between these entities and the PCP especially in areas where these services have been lacking and patient are going without needed care and services.										
Task 5 ACP will implement a referral process by which all referrals are entered and submitted via the EMR and go through an HIE. ACP partners' and associated providers' information shall be uploaded and prompted to the PCP or other referrer as a referral database so that referrals can be made to the needed service provider or agency that has made a commitment to tend to ACP patients in the specified timeframe and manner.										
Task 6 All referrals shall go through to the ACP central data repository and shall be stored and documented for monitoring and adherence to procedure.										
Task 7 Referrals going through ACP's HIE are picked up and are monitored by the ACP central care coordinators to ensure completeness and attainment of services in a timely and efficient manner and for further care coordination.										
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.										
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
evidence-based practice guidelines developed and process implemented.										
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.										
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.										
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.										
Task 1 ACP will develop and implement best practices in care management and care coordination in conjunction with Health Home partners and develop evidence based protocols for disease management.										
Task 2 Develop uniform Comprehensive Care plans which will include disease self management techniques and will also include risk reduction activities, recognizing of warning signs and family education and support materials. The Care plans will be in different languages to be given to the patient's of ACP in their appropriate language. Furthermore, the Care plans will be consistent with the Cultural sensitivities of the population/patient being served.										
Task 3 Develop Evidence based protocols for chronic diseases with the help of Primary care physicians, specialists physicians and associations such as JNC-8, American Lung Association, etc.										
Task 4 Disseminate protocols to all providers within the PPS through physician engagement meetings, physician engagement teams and IPAs.										
Task 5 With the help of the IPAs, physician champions, the PAC, and other committees, obtain physician "buy-in" support and commitment on implementation of evidence based ACP protocols.										
Task 6 Draft partner agreements sand obtain signatures from partners acknowledging participation and adherence to ACP protocols, processes and procedures.										
Task 7 Establish partnerships and agreements with social services agencies to assist in the provision of needed services and										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
implement risk reduction, +which can include protective services, shelter, housing, food, etc.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	jd593813	Other	25_PMDL2203_1_3_20160202231515_2ai_6.1-6.2_Community_Engagement_Plan.pdf	Community Engagement Plan also applies to Milestone/Task 4.3	02/02/2016 11:15 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	1.3 Protocols disseminated
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.	2.4 Tracking tool developed
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.	3.4 See IT Roadmap under IT Workstream 3.9 Tracking tool developed and will be incorporated upon development of HIE and connectivity with QE
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	4.1 ACP Providers have been surveyed and categorized as non-PCMH certified, current PCMH certified, and paper providers. Each category will indicate a level of readiness for PCMH transformation/actualization. 4.2 ACP has partnered with vendors that will serve as resources for practice transformations by following the ACP Implementation plan for each provider category type. 4.5 Registries within EHRs are live and track physician activity with DSRIP projects.
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	5.1-5.2 Criteria developed to pull data from EHRs. Data pulled quarterly to satisfy DSRIP reporting and population health initiatives. 5.4 - Claims data from MCOs also used to target at risk patients.
Develop a comprehensive care management plan for each patient	6.1 Care plans developed

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
to engage him/her in care and to reduce patient risk factors.	
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.	7.2 Health Homes and care teams engaged 7.4-7.5 PCPs and Health Homes roles defined
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).	8.5 Referral management process developed
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.	

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 2.b.iii – ED care triage for at-risk populations

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

Instructions :

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

Risk #1: Failing to close gap in the physician/patient relationship: Many cultures within our geographies are biased towards going to the ED for all care, as they see it as more convenient and immediately responsive than going to a PCP. Our PPS plans to provide population wide education and awareness campaigns to emphasize the importance of remaining connected to a Primary Care provider, working alongside our community organization partners to expand outreach into the many ethnic groups represented in the population. Additionally, the ED triage process that will be established will include a robust team of Patient Navigators available to every patient. They will connect the patient with their existing PCP, link those without a PCP to an ACP primary care provider, and schedule a timely appointment with a PCP before leaving the ED using ACP's integrated platform or the PCP's EHR portal.
Risk #2: Capacity of PCPs/Alternative Sites of Care: Our PPS is serves an underserved area with low capacity for new appointments; throughout our communities, appointment wait times of 4+ days are not uncommon. Success will require PCPs to create greater capacity and possibly extend their work hours. ACP plans to address this challenge by providing support and training to the PCPs and staff to help make their practices more efficient and patient care more satisfying. ACP will also make available Care Managers that may be able to lighten the load for the PCP through participation in patient care. Additionally, this project may create the need for additional alternative sites of care such as urgent care which ACP will be building out and staffing.
Risk #3: Lack of communications among providers: Given the unique structure of our PPS that spans more than 2,000 physicians and community based providers, communication and information sharing could pose a potential challenge. We will address this through a robust, integrated technology platform that will be accessible across all of our providers. Additionally, this initiative will rely heavily on our capability to communicate with other PPS' in our area that are also participating in the initiative. We are currently building capabilities alongside our IT vendor, eCW, and will also leverage the SHIN-NY and RHIO platforms to assist in this task.

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

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	54,167

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
10,833	13,533	71.38%	5,425	24.98%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (18,958)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
jd593813	Rosters	25_PMDL2715_1_3_20160203182851_ED_Patient_Engagement_1_of_2.xlsx	Patient Engagement File	02/03/2016 06:29 PM
jd593813	Rosters	25_PMDL2715_1_3_20160203175956_ED_Patient_Engagement_2_of_2.xlsx	Patient Engagement File	02/03/2016 06:00 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Fail	The PPS failed to meet at least 80% of its actively engaged commitments for DY1Q3. The documentation does not support the reported actively engaged numbers.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Establish ED care triage program for at-risk populations	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Stand up program based on project requirements	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Developed processes and procedures to be implemented by partner hospitals in a uniform manner that will allow for efficient ED triage, treat and release.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Develop and implement algorithm for stratifying and identifying at risk populations for early intervention. Algorithm to include those with ICDs with high HCC scores, hospital utilization, high utilizers with negative workups, SUD, high PHQ9 and GAD scores, among other criteria.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Develop patient education materials to provide patients upon release to increase health literacy and orient patients as to proper use of ER resources.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Employ and utilize patient navigators which will educate patients and coordinate care so that the patient will leave the hospital ED with a prearranged appointment to his/her PCP, if patient has no connection to a PCP then an introduction and connection shall be made with a PCMH provider within the ACP network.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #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	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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									
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Leverage ACP's strong PCP network to establish and enhance relationships between partner hospitals and primary care providers for open communication and accessibility.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Utilize physician engagement teams, IPA groups, and physician champions to engage all PCPs in ACP's network in the participation of DSRIP and educate on the importance of advanced primary care and achievement of NCQA 2014 PCMH certification.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Leverage partnerships with Health Homes and establish connectivity to these to ensure that patient information is sent in real time to Health Homes as needed due to patient's condition so patient is connected to health home for further care.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Perform IT surveys to identify provider EMR readiness, transition from paper and specific EMRs with specific detail to	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
whether MU2 ready and MU2 status.									
Task 5 Negotiate with EMR vendors to provide implementation and support assistance to all providers as needed in attainment of MU2 certification.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6 Establish ACP IT support team in conjunction with physician engagement team to provide support and assistance to providers in MU and PCMH certification.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7 Create IDS to provide timely and efficient communication and scheduling amongst all of ACP's partners, (hospitals and PCPs) as well as provide notifications to PCPs and Health Homes as appropriate.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 8 As the ramp up and build out of the IDS occurs, ACP will use hospital EHRs, FTP site, and PCP's EMR to exchange information on patients that are received and treated in the ER.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 9 Interim step: Set up relationships and connections within hospital EHRs such as EPIC et al. that provide ADT feeds to ACP's central care coordination/back office team who accept the information and process appointment follow up	Project		In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 10 The hospital feeds will be sent/received into the PCP's EMR, ACP's FTP site and as well as ACP's central care coordination/back office.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
primary care provider).									
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 ACP will employ Patient navigators in the ED that will assist the patients in the emergency room.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Train the patient navigators to educate the patient once treated and ensure that the patient receives information on and receives and appointment to a 2014 PCMH Primary Care provider.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Patient navigator will provide the patient with the appointment before the patient is discharged and will work with care coordinator in ensuring that the patient has and is able to access necessary support in the community.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	Provider	Safety Net Hospital	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 ACP will track all patients identified by the developed algorithm and continuously analyze the data which will be housed and maintained at ACP's central servers through the established feeds and interfaces between the hospital EDs and the Primary Care provider's EMR and ACP's care Coordination/Care Management system.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2 Data held and analyzed will include hospital encounter to PCP follow up visits, number of follow up visits, lag time between ER encounter, date and time appointment made and date of appointment.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3 ACP will Gather utilization data from within hospital EMR, PCP EMR and even partner EMRs. Hospital ER use and monitor and stratify based on patient condition, frequency of utilization, etc. as per algorithm which will then be fed to Care Managers and Care Coordinators and CHWs to reach out to patients, provide education, self-management techniques, medication reconciliations including refills, will connect the patient with needed social and community services, and other needed services.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Establish ED care triage program for at-risk populations										
Task Stand up program based on project requirements										
Task 1 Developed processes and procedures to be implemented by partner hospitals in a uniform manner that will allow for efficient ED triage, treat and release.										
Task 2 Develop and implement algorithm for stratifying and identifying at risk populations for early intervention. Algorithm to include those with ICDs with high HCC scores, hospital utilization, high utilizers with negative workups, SUD, high PHQ9 and GAD scores, among other criteria.										
Task 3 Develop patient education materials to provide patients upon release to increase health literacy and orient patients as to proper use of ER resources.										
Task 4 Employ and utilize patient navigators which will educate patients and coordinate care so that the patient will leave the hospital ED with a prearranged appointment to his/her PCP, if										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
patient has no connection to a PCP then an introduction and connection shall be made with a PCMH provider within the ACP network.										
Milestone #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										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	75	150	262
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	0	0	75	150	262
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	0	0	0	0	0
Task 1 Leverage ACP's strong PCP network to establish and enhance relationships between partner hospitals and primary care providers for open communication and accessibility.										
Task 2 Utilize physician engagement teams, IPA groups, and physician champions to engage all PCPs in ACP's network in the participation of DSRIP and educate on the importance of advanced primary care and achievement of NCQA 2014 PCMH certification.										
Task 3 Leverage partnerships with Health Homes and establish connectivity to these to ensure that patient information is sent in real time to Health Homes as needed due to patient's condition so patient is connected to health home for further care.										
Task 4 Perform IT surveys to identify provider EMR readiness,										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
transition from paper and specific EMRs with specific detail to whether MU2 ready and MU2 status.										
Task 5 Negotiate with EMR vendors to provide implementation and support assistance to all providers as needed in attainment of MU2 certification.										
Task 6 Establish ACP IT support team in conjunction with physician engagement team to provide support and assistance to providers in MU and PCMH certification.										
Task 7 Create IDS to provide timely and efficient communication and scheduling amongst all of ACP's partners, (hospitals and PCPs) as well as provide notifications to PCPs and Health Homes as appropriate.										
Task 8 As the ramp up and build out of the IDS occurs, ACP will use hospital EHRs, FTP site, and PCP's EMR to exchange information on patients that are received and treated in the ER.										
Task 9 Interim step: Set up relationships and connections within hospital EHRs such as EPIC et al. that provide ADT feeds to ACP's central care coordination/back office team who accept the information and process appointment follow up										
Task 10 The hospital feeds will be sent/received into the PCP's EMR, ACP's FTP site and as well as ACP's central care coordination/back office.										
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).										
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 1 ACP will employ Patient navigators in the ED that will assist the patients in the emergency room.										
Task 2 Train the patient navigators to educate the patient once treated and ensure that the patient receives information on and receives and appointment to a 2014 PCMH Primary Care provider.										
Task 3 Patient navigator will provide the patient with the appointment before the patient is discharged and will work with care coordinator in ensuring that the patient has and is able to access necessary support in the community.										
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	0	0	0	0	0	0	0	0	0	0
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 ACP will track all patients identified by the developed algorithm and continuously analyze the data which will be housed and maintained at ACP's central servers through the established feeds and interfaces between the hospital EDs and the Primary Care provider's EMR and ACP's care Coordination/Care Management system.										
Task 2 Data held and analyzed will include hospital encounter to PCP follow up visits, number of follow up visits, lag time between ER encounter, date and time appointment made and date of appointment.										
Task 3 ACP will Gather utilization data from within hospital EMR, PCP EMR and even partner EMRs. Hospital ER use and monitor and stratify based on patient condition, frequency of utilization, etc. as per algorithm which will then be fed to Care Managers and Care Coordinators and CHWs to reach out to patients, provide										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
education, self-management techniques, medication reconciliations including refills, will connect the patient with needed social and community services, and other needed services.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Establish ED care triage program for at-risk populations										
Task Stand up program based on project requirements										
Task 1 Developed processes and procedures to be implemented by partner hospitals in a uniform manner that will allow for efficient ED triage, treat and release.										
Task 2 Develop and implement algorithm for stratifying and identifying at risk populations for early intervention. Algorithm to include those with ICDs with high HCC scores, hospital utilization, high utilizers with negative workups, SUD, high PHQ9 and GAD scores, among other criteria.										
Task 3 Develop patient education materials to provide patients upon release to increase health literacy and orient patients as to proper use of ER resources.										
Task 4 Employ and utilize patient navigators which will educate patients and coordinate care so that the patient will leave the hospital ED with a prearranged appointment to his/her PCP, if patient has no connection to a PCP then an introduction and connection shall be made with a PCMH provider within the ACP network.										
Milestone #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										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	524	748	748	748	748	748	748	748	748	748
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	524	748	748	748	748	748	748	748	748	748
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	4	4	4	4	4	4	4	4	4
Task 1 Leverage ACP's strong PCP network to establish and enhance relationships between partner hospitals and primary care providers for open communication and accessibility.										
Task 2 Utilize physician engagement teams, IPA groups, and physician champions to engage all PCPs in ACP's network in the participation of DSRIP and educate on the importance of advanced primary care and achievement of NCQA 2014 PCMH certification.										
Task 3 Leverage partnerships with Health Homes and establish connectivity to these to ensure that patient information is sent in real time to Health Homes as needed due to patient's condition so patient is connected to health home for further care.										
Task 4 Perform IT surveys to identify provider EMR readiness, transition from paper and specific EMRs with specific detail to whether MU2 ready and MU2 status.										
Task 5 Negotiate with EMR vendors to provide implementation and support assistance to all providers as needed in attainment of MU2 certification.										
Task 6 Establish ACP IT support team in conjunction with physician engagement team to provide support and assistance to providers in MU and PCMH certification.										
Task 7 Create IDS to provide timely and efficient communication and scheduling amongst all of ACP's partners, (hospitals and PCPs) as well as provide notifications to PCPs and Health Homes as appropriate.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 8 As the ramp up and build out of the IDS occurs, ACP will use hospital EHRs, FTP site, and PCP's EMR to exchange information on patients that are received and treated in the ER.										
Task 9 Interim step: Set up relationships and connections within hospital EHRs such as EPIC et al. that provide ADT feeds to ACP's central care coordination/back office team who accept the information and process appointment follow up										
Task 10 The hospital feeds will be sent/received into the PCP's EMR, ACP's FTP site and as well as ACP's central care coordination/back office.										
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).										
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.										
Task 1 ACP will employ Patient navigators in the ED that will assist the patients in the emergency room.										
Task 2 Train the patient navigators to educate the patient once treated and ensure that the patient receives information on and receives and appointment to a 2014 PCMH Primary Care provider.										
Task 3 Patient navigator will provide the patient with the appointment before the patient is discharged and will work with care coordinator in ensuring that the patient has and is able to access necessary support in the community.										
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
receive more appropriate level of care. (This requirement is optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	0	0	0	0	0	0	0	0	0	0
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 ACP will track all patients identified by the developed algorithm and continuously analyze the data which will be housed and maintained at ACP's central servers through the established feeds and interfaces between the hospital EDs and the Primary Care provider's EMR and ACP's care Coordination/Care Management system.										
Task 2 Data held and analyzed will include hospital encounter to PCP follow up visits, number of follow up visits, lag time between ER encounter, date and time appointment made and date of appointment.										
Task 3 ACP will Gather utilization data from within hospital EMR, PCP EMR and even partner EMRs. Hospital ER use and monitor and stratify based on patient condition, frequency of utilization, etc. as per algorithm which will then be fed to Care Managers and Care Coordinators and CHWs to reach out to patients, provide education, self-management techniques, medication reconciliations including refills, will connect the patient with needed social and community services, and other needed services.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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	jd593813	Other	25_PMDL2703_1_3_20160203163441_3.1_ED_Triage_Protocol.pdf	ED Triage Protocol	02/03/2016 04:34 PM

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
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).					

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	1.1 Process established with partner hospital EDs.
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	
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).	3.1-3.3 ED navigators in place for key hospital partners that assists patients in the ED, trains and educates patients and provides follow-up appointment with Primary Care.
Established protocols allowing ED and first responders - under	

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Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

The major risks for this project revolve around being granted access to those hospitals who are leads in other PPS' in order to obtain patient information and patient access. Patient engagement consists of performing pre-discharge planning and the performance itself is based on providing transitional care visits to ensure stable transition and eliminate/prevent 30 day re-admissions. Without proper, timely access to the patient information and to the patient, this process is hindered. A comprehensive, effective transitional care visit which includes comprehensive medication reconciliation and effective implementation of a comprehensive plan of care are heavily reliant on having accurate information regarding both the hospital stay and the discharge plan, without access to discharge information and discharge papers, this process is impeded. To mitigate this issue, ACP is avidly reaching out to and negotiating with all of the hospitals in ACP's catchment area and to which any patient attributed to ACP may receive services from without regard to the PPS that they participate in. ACP will use MCO feeds, patient notices and other resources to reach patients as early as possible while the negotiations are going on and while the connection to RHIOs is being worked out.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	81,988

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
19,326	31,480	95.99%	1,315	38.40%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (32,795)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
jd593813	Rosters	25_PMDL2815_1_3_20160203193558_CT_Patient_Engagement_2_of_3.xlsx	Patient Engagement File 2 of 3	02/03/2016 07:36 PM
jd593813	Rosters	25_PMDL2815_1_3_20160203193525_CT_Patient_Engagement_3_of_3.xlsx	Patient Engagement File 3 of 3	02/03/2016 07:35 PM
jd593813	Rosters	25_PMDL2815_1_3_20160203193442_CT_Patient_Engagement_1_of_3.xlsx	Patient Engagement File 1 of 3	02/03/2016 07:34 PM

Narrative Text :

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

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Develop Care transitions intervention model to include pre-discharge and post discharge patient contact, assessment and intervention.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Develop pre-discharge plan template using evidence based standards in accordance with national standards	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 3 Review pre-discharge plan requirements with partner hospitals and ensure that pre-discharge plans are standard and meet ACP's standards both in components and timing.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4 Develop reporting methods for monitoring pre-discharge plans performed in the inpatient hospital setting.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5 Convene Transitional Care project physician leads to draft, review and approve evidence based protocol for care transitions post discharge visit.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 6 Develop and implement standardized protocol for transitional care visits which include comprehensive medication reconciliation, assessments and interventions for conditions that have the highest incidence of hospital readmissions and the	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
performance of which have proven to reduce re-hospitalizations such as fall risk assessments and implementing fall risk reduction plans amongst others. The protocol also calls for assessing patient's overall needs including social support referrals, DMEs, specialty services, home care, etc. for providing care for the patient in a team approach.									
Task 7 Engage home care service agencies, social service agencies, home delivery services, and others as partners of the PPS to provide needed services to ACP patients. These agencies will serve on ACP's care Teams, PAC, Clinical Quality committees to assist the PPS in providing a team approach to patient care.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 8 Disseminate post discharge standardized protocol to ACP providers using ACP's provider engagement teams, PAC, Care Teams, etc.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Disseminate care transitions protocols to MCOs and health homes working with ACP for the implementation.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Liaise and Coordinate between MCOs and Health Homes in the provision and coverage for services needed during the post	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
discharge period.									
Task 3 Forge relationships with upper management at MCOs and Health Homes to bring appropriate level individuals to the negotiations table.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4 Elaborate and Negotiate and a payment strategy for transitional care visits including those done at PCP's office and those done at the patient's home as needed.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5 Elaborate and negotiate a payment for services rendered in the Care Management and care coordination of transitional care services in coordination with the Health homes.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6 Establish care coordination/back office team to receive feeds/reports from inpatient hospitals, MCOs and implement care coordination immediately to facilitate and ensure higher compliance rate and higher patient engagement rates.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7 Establish Care Coordination processes and procedures indicating receipt of feed and processing of the information in a timely manner, attainment of pre-discharge plans, coordinating of care through social supports, specialty, home care, delivery and transitional care post discharge visits.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 8 Establish care Coordination platform, EMR, by which all data, patient information will be tracked.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 9 Establish clear lines of communication between ACP central care coordination and outreach and the Health Homes within the network.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10 Develop and Implement Health Home protocol that includes a clear definition of Health Home eligible and a clear process by which patient shall be linked to the Health Home.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 11 Train all care managers and care coordinators on Health Home eligibility and process for referring.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
12 Train all ACP providers on Health Home eligibility and process for referring.									
Milestone #3 Ensure required social services participate in the project.	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Engage social service and social support entities in ACP's network.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Incorporate social service and social support entities in ACP Care Teams and PAC. Social support services such as meal delivery services, God's Love we Deliver; Interim housing/shelters such as VIP are a part of ACP's network, Care Teams and PAC.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospital	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task ACP has worked with and negotiated with hospital partners and hospitals in other PPS', the hospitals will provide transition care managers and/or pre-discharge planners to develop and review discharge planning while the patient is still inpatient. The	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
discharge plan and summary will be made available to the TC partner and to the PCP for more accurate and efficient treatment. The pre-discharge plan will also be used to coordinate needed services such as social support, home care, DME, etc. and the Transitional Care visit.									
Task 1 Establish processes with partner hospitals in which a care transitions/pre-discharge plan nurse or care manager establishes the link with the patient and provides the pre-discharge plan at the patient's side, while the patient is still inpatient in accordance with the established transitional care protocol and standardized pre-discharge plan.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Partner hospital will allow access to the patient to the care transition pre-discharge pan manager/nurse and in most cases the care manager/nurse will be a hospital staff member since ACP's partner hospitals have care transitions staff already on hand..	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Processes are in place to receive feeds from hospitals and MCOs on a daily basis of all admissions allowing for early notification of hospitalizations and thereby early access to patients for the provision of discharge planning.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Processes and procedures are in place for prompt action upon receipt of the inpatient data feeds to begin the process of accessing the patient and implementing the plan.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 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.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Develop processes as mandated by protocol for transmission	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
of Care transitions records to member's provider/PCP within 48 hours of Transitional Care visit.									
Task 2 Utilizing guidelines from the National Transition of Care Coalition and working with the expertise of ACP partners who specialize in Care Transitions, ACP will bring together a standardized protocol/standard of care and processes for providing quality Care Transitions services. Protocol/Standard of Care to include comprehensive medication reconciliation, comprehensive evaluation, HEDIS assessments, ADL assessments, Fall risk, etc.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Implement process as mandated by protocol by which member's provider/PCP receives Transitional Care visit records within 48hours.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Utilize EMR to transmit records to member's provider via P2P portal, FTP, HIE, RHIO or ACP platform to be created.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 1 Implement care transition protocol mandate calculation of 30 day period to start on the date of discharge as day 0 and the day following discharge as day 1 up to 30 calendar days.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Processes are in place in which upon receipt of inpatient feeds, Care Transitions team ensures that all relevant patient data including diagnoses, demographics, etc. are entered into EMR.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
2 Utilizing Care transitions team's EMR structured fields all patient data is entered, gathered and filtered for evaluation of engagement efforts, successes and improvements.									
Task 3 Data mining from Care Transitions team's EMR and additional electronic systems are used to provide stratification, target identification and outreach population wide, patient specific and overall tracking and reporting.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Additional data filters and repositories are created within hospital EMR, ACP central Care Coordination systems for redundancy, data verification and comparison analytics.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task 1 Develop Care transitions intervention model to include pre-discharge and post discharge patient contact, assessment and intervention.										
Task 2 Develop pre-discharge plan template using evidence based standards in accordance with national standards										
Task 3 Review pre-discharge plan requirements with partner hospitals and ensure that pre-discharge plans are standard and meet ACP's standards both in components and timing.										
Task 4 Develop reporting methods for monitoring pre-discharge plans performed in the inpatient hospital setting.										
Task 5 Convene Transitional Care project physician leads to draft, review and approve evidence based protocol for care transitions post discharge visit.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 6 Develop and implement standardized protocol for transitional care visits which include comprehensive medication reconciliation, assessments and interventions for conditions that have the highest incidence of hospital readmissions and the performance of which have proven to reduce re-hospitalizations such as fall risk assessments and implementing fall risk reduction plans amongst others. The protocol also calls for assessing patient's overall needs including social support referrals, DMEs, specialty services, home care, etc. for providing care for the patient in a team approach.										
Task 7 Engage home care service agencies, social service agencies, home delivery services, and others as partners of the PPS to provide needed services to ACP patients. These agencies will serve on ACP's care Teams, PAC, Clinical Quality committees to assist the PPS in providing a team approach to patient care.										
Task 8 Disseminate post discharge standardized protocol to ACP providers using ACP's provider engagement teams, PAC, Care Teams, etc.										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task 1 Disseminate care transitions protocols to MCOs and health homes working with ACP for the implementation.										
Task 2 Liaise and Coordinate between MCOs and Health Homes in the provision and coverage for services needed during the post discharge period.										
Task 3 Forge relationships with upper management at MCOs and										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Health Homes to bring appropriate level individuals to the negotiations table.										
Task 4 Elaborate and Negotiate and a payment strategy for transitional care visits including those done at PCP's office and those done at the patient's home as needed.										
Task 5 Elaborate and negotiate a payment for services rendered in the Care Management and care coordination of transitional care services in coordination with the Health homes.										
Task 6 Establish care coordination/back office team to receive feeds/reports from inpatient hospitals, MCOs and implement care coordination immediately to facilitate and ensure higher compliance rate and higher patient engagement rates.										
Task 7 Establish Care Coordination processes and procedures indicating receipt of feed and processing of the information in a timely manner, attainment of pre-discharge plans, coordinating of care through social supports, specialty, home care, delivery and transitional care post discharge visits.										
Task 8 Establish care Coordination platform, EMR, by which all data, patient information will be tracked.										
Task 9 Establish clear lines of communication between ACP central care coordination and outreach and the Health Homes within the network.										
Task 10 Develop and Implement Health Home protocol that includes a clear definition of Health Home eligible and a clear process by which patient shall be linked to the Health Home.										
Task 11 Train all care managers and care coordinators on Health Home eligibility and process for referring.										
Task 12 Train all ACP providers on Health Home eligibility and process for referring.										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task 1 Engage social service and social support entities in ACP's										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
network.										
Task 2 Incorporate social service and social support entities in ACP Care Teams and PAC. Social support services such as meal delivery services, God's Love we Deliver; Interim housing/shelters such as VIP are a part of ACP's network, Care Teams and PAC.										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	46	136	226	451	902	902	902
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	72	215	357	714	1,428	1,428	1,428
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	1	2	4	7	13	13	13
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task ACP has worked with and negotiated with hospital partners and hospitals in other PPS', the hospitals will provide transition care managers and/or pre-discharge planners to develop and review discharge planning while the patient is still inpatient. The discharge plan and summary will be made available to the TC partner and to the PCP for more accurate and efficient treatment. The pre-discharge plan will also be used to coordinate needed services such as social support, home care, DME, etc. and the Transitional Care visit.										
Task 1 Establish processes with partner hospitals in which a care transitions/pre-discharge plan nurse or care manager establishes the link with the patient and provides the pre-discharge plan at the patient's side, while the patient is still inpatient in accordance with the established transitional care protocol and standardized pre-discharge plan.										
Task 2 Partner hospital will allow access to the patient to the care										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
transition pre-discharge pan manager/nurse and in most cases the care manager/nurse will be a hospital staff member since ACP's partner hospitals have care transitions staff already on hand..										
Task 3 Processes are in place to receive feeds from hospitals and MCOs on a daily basis of all admissions allowing for early notification of hospitalizations and thereby early access to patients for the provision of discharge planning.										
Task 4 Processes and procedures are in place for prompt action upon receipt of the inpatient data feeds to begin the process of accessing the patient and implementing the plan.										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task 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.										
Task 1 Develop processes as mandated by protocol for transmission of Care transitions records to member's provider/PCP within 48 hours of Transitional Care visit.										
Task 2 Utilizing guidelines from the National Transition of Care Coalition and working with the expertise of ACP partners who specialize in Care Transitions, ACP will bring together a standardized protocol/standard of care and processes for providing quality Care Transitions services. Protocol/Standard of Care to include comprehensive medication reconciliation, comprehensive evaluation, HEDIS assessments, ADL assessments, Fall risk, etc.										
Task 3 Implement process as mandated by protocol by which member's provider/PCP receives Transitional Care visit records within 48hours.										
Task 4 Utilize EMR to transmit records to member's provider via P2P portal, FTP, HIE, RHIO or ACP platform to be created.										
Milestone #6 Ensure that a 30-day transition of care period is established.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task 1 Implement care transition protocol mandate calculation of 30 day period to start on the date of discharge as day 0 and the day following discharge as day 1 up to 30 calendar days.										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Processes are in place in which upon receipt of inpatient feeds, Care Transitions team ensures that all relevant patient data including diagnoses, demographics, etc. are entered into EMR.										
Task 2 Utilizing Care transitions team's EMR structured fields all patient data is entered, gathered and filtered for evaluation of engagement efforts, successes and improvements.										
Task 3 Data mining from Care Transitions team's EMR and additional electronic systems are used to provide stratification, target identification and outreach population wide, patient specific and overall tracking and reporting.										
Task 4 Additional data filters and repositories are created within hospital EMR, ACP central Care Coordination systems for redundancy, data verification and comparison analytics.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task 1 Develop Care transitions intervention model to include pre-discharge and post discharge patient contact, assessment and intervention.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 2 Develop pre-discharge plan template using evidence based standards in accordance with national standards										
Task 3 Review pre-discharge plan requirements with partner hospitals and ensure that pre-discharge plans are standard and meet ACP's standards both in components and timing.										
Task 4 Develop reporting methods for monitoring pre-discharge plans performed in the inpatient hospital setting.										
Task 5 Convene Transitional Care project physician leads to draft, review and approve evidence based protocol for care transitions post discharge visit.										
Task 6 Develop and implement standardized protocol for transitional care visits which include comprehensive medication reconciliation, assessments and interventions for conditions that have the highest incidence of hospital readmissions and the performance of which have proven to reduce re-hospitalizations such as fall risk assessments and implementing fall risk reduction plans amongst others. The protocol also calls for assessing patient's overall needs including social support referrals, DMEs, specialty services, home care, etc. for providing care for the patient in a team approach.										
Task 7 Engage home care service agencies, social service agencies, home delivery services, and others as partners of the PPS to provide needed services to ACP patients. These agencies will serve on ACP's care Teams, PAC, Clinical Quality committees to assist the PPS in providing a team approach to patient care.										
Task 8 Disseminate post discharge standardized protocol to ACP providers using ACP's provider engagement teams, PAC, Care Teams, etc.										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task 1 Disseminate care transitions protocols to MCOs and health homes working with ACP for the implementation.										
Task 2 Liaise and Coordinate between MCOs and Health Homes in the provision and coverage for services needed during the post discharge period.										
Task 3 Forge relationships with upper management at MCOs and Health Homes to bring appropriate level individuals to the negotiations table.										
Task 4 Elaborate and Negotiate and a payment strategy for transitional care visits including those done at PCP's office and those done at the patient's home as needed.										
Task 5 Elaborate and negotiate a payment for services rendered in the Care Management and care coordination of transitional care services in coordination with the Health homes.										
Task 6 Establish care coordination/back office team to receive feeds/reports from inpatient hospitals, MCOs and implement care coordination immediately to facilitate and ensure higher compliance rate and higher patient engagement rates.										
Task 7 Establish Care Coordination processes and procedures indicating receipt of feed and processing of the information in a timely manner, attainment of pre-discharge plans, coordinating of care through social supports, specialty, home care, delivery and transitional care post discharge visits.										
Task 8 Establish care Coordination platform, EMR, by which all data, patient information will be tracked.										
Task 9 Establish clear lines of communication between ACP central care coordination and outreach and the Health Homes within the network.										
Task 10 Develop and Implement Health Home protocol that includes a clear definition of Health Home eligible and a clear process by										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
which patient shall be linked to the Health Home.										
Task 11 Train all care managers and care coordinators on Health Home eligibility and process for referring.										
Task 12 Train all ACP providers on Health Home eligibility and process for referring.										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task 1 Engage social service and social support entities in ACP's network.										
Task 2 Incorporate social service and social support entities in ACP Care Teams and PAC. Social support services such as meal delivery services, God's Love we Deliver; Interim housing/shelters such as VIP are a part of ACP's network, Care Teams and PAC.										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task Policies and procedures are in place for early notification of planned discharges.	902	902	902	902	902	902	902	902	902	902
Task Policies and procedures are in place for early notification of planned discharges.	1,428	1,428	1,428	1,428	1,428	1,428	1,428	1,428	1,428	1,428
Task Policies and procedures are in place for early notification of planned discharges.	13	13	13	13	13	13	13	13	13	13
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task ACP has worked with and negotiated with hospital partners and hospitals in other PPS', the hospitals will provide transition care managers and/or pre-discharge planners to develop and review discharge planning while the patient is still inpatient. The										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
discharge plan and summary will be made available to the TC partner and to the PCP for more accurate and efficient treatment. The pre-discharge plan will also be used to coordinate needed services such as social support, home care, DME, etc. and the Transitional Care visit.										
Task 1 Establish processes with partner hospitals in which a care transitions/pre-discharge plan nurse or care manager establishes the link with the patient and provides the pre-discharge plan at the patient's side, while the patient is still inpatient in accordance with the established transitional care protocol and standardized pre-discharge plan.										
Task 2 Partner hospital will allow access to the patient to the care transition pre-discharge pan manager/nurse and in most cases the care manager/nurse will be a hospital staff member since ACP's partner hospitals have care transitions staff already on hand..										
Task 3 Processes are in place to receive feeds from hospitals and MCOs on a daily basis of all admissions allowing for early notification of hospitalizations and thereby early access to patients for the provision of discharge planning.										
Task 4 Processes and procedures are in place for prompt action upon receipt of the inpatient data feeds to begin the process of accessing the patient and implementing the plan.										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task 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.										
Task 1 Develop processes as mandated by protocol for transmission of Care transitions records to member's provider/PCP within 48 hours of Transitional Care visit.										
Task 2 Utilizing guidelines from the National Transition of Care Coalition and working with the expertise of ACP partners who specialize in Care Transitions, ACP will bring together a standardized protocol/standard of care and processes for										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
providing quality Care Transitions services. Protocol/Standard of Care to include comprehensive medication reconciliation, comprehensive evaluation, HEDIS assessments, ADL assessments, Fall risk, etc.										
Task 3 Implement process as mandated by protocol by which member's provider/PCP receives Transitional Care visit records within 48hours.										
Task 4 Utilize EMR to transmit records to member's provider via P2P portal, FTP, HIE, RHIO or ACP platform to be created.										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task 1 Implement care transition protocol mandate calculation of 30 day period to start on the date of discharge as day 0 and the day following discharge as day 1 up to 30 calendar days.										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Processes are in place in which upon receipt of inpatient feeds, Care Transitions team ensures that all relevant patient data including diagnoses, demographics, etc. are entered into EMR.										
Task 2 Utilizing Care transitions team's EMR structured fields all patient data is entered, gathered and filtered for evaluation of engagement efforts, successes and improvements.										
Task 3 Data mining from Care Transitions team's EMR and additional electronic systems are used to provide stratification, target identification and outreach population wide, patient specific and overall tracking and reporting.										
Task 4 Additional data filters and repositories are created within hospital EMR, ACP central Care Coordination systems for redundancy, data verification and comparison analytics.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Ensure required social services participate in the project.	jd593813	Documentation/Certification	25_PMDL2803_1_3_20160315231400_2biv_Social_Service_Providers_Participation_2_of_2.pdf	Remediation response to 2biv Milestone 3 - Social Service providers participation	03/15/2016 11:14 PM
	jd593813	Documentation/Certification	25_PMDL2803_1_3_20160315231256_2biv_Social_Service_Providers_Participation_1_of_2.pdf	Remediation response to 2biv Milestone 3 - Social Service providers participation	03/15/2016 11:12 PM
	jd593813	Other	25_PMDL2803_1_3_20160203161839_Care_Transitions_3.1_Text.docx	Proxy file upload - care transitions text.	02/03/2016 04:18 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	1.4 Reporting and tracking of pre-discharge plans in place for key partner hospitals. 1.7 All provider types engaged based on patient need. 1.8 Protocols distributed to partner hospitals.
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.	2.1 Protocols disseminated 2.2 Coordination in place for MCO and Health Homes regarding project requirements
Ensure required social services participate in the project.	3.1 Social services and support network providers have been engaged and are part of care teams, PAC.
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.	4.1 Care transitions process in place with key partner hospitals.
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	5.2-5.3 Protocols established
Ensure that a 30-day transition of care period is established.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

Milestone Review Status

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

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

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	215,344

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
53,836	93,096	66.51%	46,877	43.23%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (139,973)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
jd593813	Rosters	25_PMDL3715_1_3_20160203165521_PCP-BH_Patient_Engagement.xlsx	Patient Engagement File	02/03/2016 04:55 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Survey and group all participating providers (safety net and non safety net) into level of readiness.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Develop plan, timelines, and assign resources for each level of readiness.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Clinical governance committee approves partner assessment results and PCMH roadmap.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5 Implement plan.		Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task 6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.		Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 1 In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Develop procedures to implement evidence based protocols with prescribed assessment tools including PHQ2/9, GAD, DAST, Audit C and SBIRT, stepped care, care team meetings, number of prescribers, etc.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 5 Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6 Establish Care teams within the practice to include care coordination to follow patients and provide "warm handoffs"		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 7 Establish procedure for "warm handoffs"		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8 In accordance with evidence based care protocols, implement process for medication prescribing and management. The process will delineate one prescriber process.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9 Develop processes and procedures for care coordinators and care managers to engage in patient treatment as per protocols.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 1	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Screenings are documented in Electronic Health Record.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1 Integrate assessment tools, PHQ2/9, DAST, Audit C and GAD into EMR for ease of access, and tracking and, monitoring		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, Audit C, DAST for all patients. Set as mandatory fields within EMR whenever		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
possible.										
Task 3 Implement SBIRT as per established, implemented protocols.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 4 Create processes for referral and "warm handoffs". Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for add -ins to schedule as necessary for "warm handoffs" from PCP		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of "warm handoff" as well as monitoring the hand off.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6 Allow creation within EMR of separate encounter for each provider, PCP and BH, on the same day within single patient record and single billing claim record.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
assessments and assessment results.										
Task 3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4 Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP platforms, interfaces, and others.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #5 Co-locate primary care services at behavioral health sites.	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Provide office space and staff for provision of full primary care services		Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2 Contract with EMR to ensure functionality provides for scheduling for both provider types within the same EMR where patient has a single record.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3 Contract with EMR to add PCP licenses and templates for full documentation capabilities within the EMR and ensure a single repository of health information and data sharing amongst providers.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Partner with EMR vendor to ensure that security features are activated to ensure patient privacy and confidentiality of secure notes.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5 Ensure that confidentiality agreements are in place between providers for data use and exchange of information.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6 Develop and implement processes for physical medicine assessments within the BH workflow to identify potential health problems and provide early intervention, disease prevention and higher quality of care for BH patients		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 1 In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Establish formal meeting schedules amongst collaborating partners to establish collaborative care and		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
best practices.										
Task 3 Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Implement evidence based protocols with prescribed assessment tools, SBRIT, stepped care, care team meetings, number of prescribers, etc.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 5 Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6 Establish Care teams within the practice to include care coordination to follow patients and provide "warm handoffs"		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 7 Establish procedure for "warm handoffs".		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 2	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Screenings are documented in Electronic Health Record.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Electronic Health Record.										
Task 1 Integrate assessment tools, PHQ2/9, DAST and GAD into EMR for ease of access and tracking, monitoring.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, DAST for all patients. Set mandatory fields within EMR whenever possible.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Implement SBRIT as per established, implemented protocols		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 4 Define protocols for screening for physical illness. Screenings to include illnesses such as Diabetes, Cardiovascular disease, Cancer screenings, etc. as well as implement other illness preventions such as immunizations.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 5 Create processes for "warm handoffs". Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for ad ins to schedule as necessary for PCP "warm handoffs"		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of "warm handoff" as well as monitoring the hand off.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7 Allow creation within EMR of separate encounter for each provider, PCP and BH, on the same day within single patient record and single billing claim record.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4 Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP platforms, interfaces, and others		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 In conjunction with physician leads and in accordance		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
with SAHMSA guidelines develop evidence based protocols for the evaluation and treatment of Behavioral health conditions by the Primary cAre Provider consistent with IMPACT model of integrated care. Protocol also includes GAD, DAST, Audit C assessments and includes SBIRT, stepped care and quadrant clinical care.										
Task 2 Deploy physician engagement team to PCP practices to engage PCPs, distribute and train on evidence based protocol and secure commitment of PCP in the implementation of IMPACT.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Through Physician engagement meetings provide a forum for PCPs to learn about IMPACT, receive protocols and review processes.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 4 Incorporate assessment tools, PHQ2/9, GAD, Audit C and DAST into practice EMR.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 5 Employ assessment tools in EMR on all patients at PCP visits and SBIRT to identify patients in need of care early and provide intervention.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 6 Hire and train Depression care managers to provide services consistent with IMPACT model of care at PCP sites.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7 Develop and implement process and procedures for assigning Care managers.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 8 Develop and implement processes and timelines by which Depression care manager will engage, evaluate and implement treatment plan with patient		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 9 Develop communications process between Depression care Manager and PCP.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
10 Develop communications process between Depression Care manager and supervising psychiatrist.										
Task 11 Develop and implement process by which Depression care manager will document follow ups and patient encounters, treatment adjustments and/or compliance within the PCP's EMR.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 12 Develop processes to connect with the different provider types within the ACP Care Teams to provide complete care to patients for all aspects of care. These processes shall include Integrated Delivery System and the use of the ACP care managers and care coordinators to monitor referrals, services and ensure timely delivery of services to patients.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Model 3	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Policies and procedures include process for consulting with Psychiatrist.		Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1 Develop processes to implement collaborative care standards as required in ACP evidence based protocols.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Create policies and procedures for engaging patients and assigning care team member, depression Care manager.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3 Create processes per evidence based protocols for implementation of care including single prescriber, stepped care consistent with IMPACT model.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 4 Hire, train and deploy Depression care managers to provide care for engaged patients in collaboration with PCP and IMPACT model		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5 Develop processes for creating a secure data repository to be accessed by supervising psychiatrist for monitoring and evaluation of the efficacy of care in accordance with IMPACT model.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6 Develop process for assigning supervising psychiatrist.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7 Establish care team meeting schedules for review of treatment plans with Care managers and PCPs as well as care coordinators as needed.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 8 Establish processes for continuous open lines of communication between PCP and care manager.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 9 Establish clear process per evidence based protocol for consulting with Psychiatrist. When consult from psychiatrist is required and completed, psychiatrist will provide treatment recommendations and the single prescriber will remain the PCP in order to maintain the integrity of the IMPACT model.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
relapse prevention plan.										
Task 1 ACP will hire and deploy depression care managers in accordance with the IMPACT model. The Depression Care manager will assist the PCP in implementing treatment plans, counseling and will monitor progress, medication refills and adjustment as adjusted by the prescribing provider.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2 Develop process and procedures for Depression care manager to access and work with Care coordinators to coordinate services for patients including social supports, home care, specialty services, etc.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3 Develop ACP Care Manager training materials to Educate and train depression Care managers on ACP's referral processes and network Regional Care team providers, level of services available and accessibility to ensure that Care managers are familiar with ACP partners and their services in order to provide patients timely and efficient access to care.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Develop programs for continuing education for depression care managers to assist in providing and maintaining high standards of care to patients in implementation of care and treatment plans.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5 Develop training manuals for depression care manager on EMRs used at PCP practices for documentation of all services and assessments within the single EMR. Training will be concise and focused on documenting all encounters, assessments and treatment plans in a format amenable to extracting data for metrics and performance reporting.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6 Develop depression care manager roles and responsibilities to include all services to be provided to		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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patient in accordance with IMPACT model care guidelines.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Model 3	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1 Engage psychiatrists and establish service agreements with ACP network psychiatrists to provide supervision of treatment plans and assessments consistent with the IMPACT model such as with Dr. Fernando Taveras and Dr. Rodney Campos, amongst others.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Create a secure site for repository of information to be accessed by psychiatrists. Site will hold treatment and assessment note on patients engaged in the IMPACT model which will be evaluated by supervising psychiatrist assigned to the patient.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Develop a process for assigning patients to designated psychiatrist. Designations will be based primarily on patient's language, culture and relationship with the PCP and the community being served. This criteria will allow for a greater understanding of the patient's social conditions as well as a greater chance of compliance if psychiatrist face to face consult is required at a later time.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Develop process by which Depression Care manager uploads patient information into Psychiatrist's secure site.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1 Incorporate assessment tools, ie. PHQ9 into PCP's EMR		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Implement procedures for periodic repeat assessments in accordance with stepped care prescribed in evidence based protocol performed by the Depression care manager within the PCP's EMR.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 3 Work with EMR vendors to Create filters and reportable fields that will allow the extrapolating of assessment data. ACP will rely on reportable data from MU dashboards, PCMH data fields, patient registries and others.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Use PCP's EMR to extrapolate comparison data, flow sheets to establish trends in symptoms based on assessment responses and measure outcomes.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Implement Stepped care in accordance with ACP evidence based protocol, patients with positive PHQ9 values requiring treatment shall be treated as per specified treatment options and in stepped care by the PCP		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Process is created for assignment of patient to Depression care manager for continuity of care and monitoring.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Process is created for continuous open lines of communication between Depression care manager and PCP, and on site care team as necessary.		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 In line with stepped care, Depression Care manager		Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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performs follow up PHQ9 assessment in intervals to ascertain effectiveness of treatment and make appropriate adjustments after consulting with PCP.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 3	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Working with EMR vendors, assessment tools are incorporated within EMRs in a format that is reportable in which data is ascertainable.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Develop process for extrapolating and reporting data to track and monitor all engaged patients.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Create FTP secure site and or other IDS platform for providing data to supervising psychiatrist and exchanging information.		Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 4 Create connection and interfaces with other platforms including Care coordination/management platform, ACP IDS for open efficient exchange of information and more effective patient care.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM	0	0	0	91	181	316	632	902	902	902

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
standards by the end of DY3.										
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	7	20	33	65	130	130	130
Task 1 Survey and group all participating providers (safety net and non safety net) into level of readiness.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness.										
Task 3 Clinical governance committee approves partner assessment results and PCMH roadmap.										
Task 4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).										
Task 5 Implement plan.										
Task 6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.										
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.										
Task 1 In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.										
Task 2 Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices.										
Task 3 Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder,										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Developmentally Disabled providers, etc.										
Task 4 Develop procedures to implement evidence based protocols with prescribed assessment tools including PHQ2/9, GAD, DAST, Audit C and SBIRT, stepped care, care team meetings, number of prescribers, etc.										
Task 5 Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers.										
Task 6 Establish Care teams within the practice to include care coordination to follow patients and provide "warm handoffs"										
Task 7 Establish procedure for "warm handoffs"										
Task 8 In accordance with evidence based care protocols, implement process for medication prescribing and management. The process will delineate one prescriber process.										
Task 9 Develop processes and procedures for care coordinators and care managers to engage in patient treatment as per protocols.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	46	136	226	451	902	902	902
Task 1 Integrate assessment tools, PHQ2/9, DAST, Audit C and GAD into EMR for ease of access, and tracking and, monitoring										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, Audit C, DAST for all patients. Set as mandatory fields within EMR whenever possible.										
Task 3 Implement SBIRT as per established, implemented protocols.										
Task 4 Create processes for referral and "warm handoffs". Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for add -ins to schedule as necessary for "warm handoffs" from PCP										
Task 5 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of "warm handoff" as well as monitoring the hand off.										
Task 6 Allow creation within EMR of separate encounter for each provider, PCP and BH, on the same day within single patient record and single billing claim record.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR.										
Task 2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.										
Task 3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 4 Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.										
Task 5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP platforms, interfaces, and others.										
Milestone #5 Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	0	0	0	0	0	0	0	91	181	316
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	1	2	4	7	13	13	13
Task 1 Provide office space and staff for provision of full primary care services										
Task 2 Contract with EMR to ensure functionality provides for scheduling for both provider types within the same EMR where patient has a single record.										
Task 3 Contract with EMR to add PCP licenses and templates for full documentation capabilities within the EMR and ensure a single repository of health information and data sharing amongst providers.										
Task 4 Partner with EMR vendor to ensure that security features are activated to ensure patient privacy and confidentiality of secure notes.										
Task 5 Ensure that confidentiality agreements are in place between providers for data use and exchange of information.										
Task 6 Develop and implement processes for physical medicine assessments within the BH workflow to identify potential health problems and provide early intervention, disease prevention and higher quality of care for BH patients										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.										
Task 1 In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.										
Task 2 Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices.										
Task 3 Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc.										
Task 4 Implement evidence based protocols with prescribed assessment tools, SBRIT, stepped care, care team meetings, number of prescribers, etc.										
Task 5 Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers.										
Task 6 Establish Care teams within the practice to include care coordination to follow patients and provide "warm handoffs"										
Task 7 Establish procedure for "warm handoffs".										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	46	136	226	451	902	902	902	902
Task 1 Integrate assessment tools, PHQ2/9, DAST and GAD into EMR for ease of access and tracking, monitoring.										
Task 2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, DAST for all patients. Set mandatory fields within EMR whenever possible.										
Task 3 Implement SBRIT as per established, implemented protocols										
Task 4 Define protocols for screening for physical illness. Screenings to include illnesses such as Diabetes, Cardiovascular disease, Cancer screenings, etc. as well as implement other illness preventions such as immunizations.										
Task 5 Create processes for "warm handoffs". Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for ad ins to schedule as necessary for PCP "warm handoffs"										
Task 6 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of "warm handoff" as well as monitoring the hand off.										
Task 7 Allow creation within EMR of separate encounter for each provider, PCP and BH, on the same day within single patient record and single billing claim record.										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR										
Task 2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.										
Task 3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.										
Task 4 Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.										
Task 5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP platforms, interfaces, and others										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	46	136	226	451	902	902	902	902
Task 1 In conjunction with physician leads and in accordance with SAHMSA guidelines develop evidence based protocols for the evaluation and treatment of Behavioral health conditions by the Primary cAre Provider consistent with IMPACT model of integrated care. Protocol also includes GAD, DAST, Audit C assessments and includes SBIRT, stepped care and quadrant clinical care.										
Task 2 Deploy physician engagement team to PCP practices to engage PCPs, distribute and train on evidence based protocol and secure commitment of PCP in the implementation of										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
IMPACT.										
Task 3 Through Physician engagement meetings provide a forum for PCPs to learn about IMPACT, receive protocols and review processes.										
Task 4 Incorporate assessment tools, PHQ2/9, GAD, Audit C and DAST into practice EMR.										
Task 5 Employ assessment tools in EMR on all patients at PCP visits and SBIRT to identify patients in need of care early and provide intervention.										
Task 6 Hire and train Depression care managers to provide services consistent with IMPACT model of care at PCP sites.										
Task 7 Develop and implement process and procedures for assigning Care managers.										
Task 8 Develop and implement processes and timelines by which Depression care manager will engage, evaluate and implement treatment plan with patient										
Task 9 Develop communications process between Depression care Manager and PCP.										
Task 10 Develop communications process between Depression Care manager and supervising psychiatrist.										
Task 11 Develop and implement process by which Depression care manager will document follow ups and patient encounters, treatment adjustments and/or compliance within the PCP's EMR.										
Task 12 Develop processes to connect with the different provider types within the ACP Care Teams to provide complete care to patients for all aspects of care. These processes shall include Integrated Delivery System and the use of the ACP care managers and care coordinators to monitor referrals, services and ensure timely delivery of services to patients.										
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										

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

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Task 1 ACP will hire and deploy depression care managers in accordance with the IMPACT model. The Depression Care manager will assist the PCP in implementing treatment plans, counseling and will monitor progress, medication refills and adjustment as adjusted by the prescribing provider.										
Task 2 Develop process and procedures for Depression care manager to access and work with Care coordinators to coordinate services for patients including social supports, home care, specialty services, etc.										
Task 3 Develop ACP Care Manager training materials to Educate and train depression Care managers on ACP's referral processes and network Regional Care team providers, level of services available and accessibility to ensure that Care managers are familiar with ACP partners and their services in order to provide patients timely and efficient access to care.										
Task 4 Develop programs for continuing education for depression care managers to assist in providing and maintaining high standards of care to patients in implementation of care and treatment plans.										
Task 5 Develop training manuals for depression care manager on EMRs used at PCP practices for documentation of all services and assessments within the single EMR. Training will be concise and focused on documenting all encounters, assessments and treatment plans in a format amenable to extracting data for metrics and performance reporting.										
Task 6 Develop depression care manager roles and responsibilities to include all services to be provided to patient in accordance with IMPACT model care guidelines.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT										

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Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task 1 Engage psychiatrists and establish service agreements with ACP network psychiatrists to provide supervision of treatment plans and assessments consistent with the IMPACT model such as with Dr. Fernando Taveras and Dr. Rodney Campos, amongst others.										
Task 2 Create a secure site for repository of information to be accessed by psychiatrists. Site will hold treatment and assessment note on patients engaged in the IMPACT model which will be evaluated by supervising psychiatrist assigned to the patient.										
Task 3 Develop a process for assigning patients to designated psychiatrist. Designations will be based primarily on patient's language, culture and relationship with the PCP and the community being served. This criteria will allow for a greater understanding of the patient's social conditions as well as a greater chance of compliance if psychiatrist face to face consult is required at a later time.										
Task 4 Develop process by which Depression Care manager uploads patient information into Psychiatrist's secure site.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task 1 Incorporate assessment tools, ie. PHQ9 into PCP's EMR										
Task 2 Implement procedures for periodic repeat assessments in accordance with stepped care prescribed in evidence based protocol performed by the Depression care manager within the PCP's EMR.										
Task 3 Work with EMR vendors to Create filters and reportable fields that will allow the extrapolating of assessment data. ACP will rely on reportable data from MU dashboards, PCMH data fields,										

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

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Task 3 Create FTP secure site and or other IDS platform for providing data to supervising psychiatrist and exchanging information.										
Task 4 Create connection and interfaces with other platforms including Care coordination/management platform, ACP IDS for open efficient exchange of information and more effective patient care.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	902	902	902	902	902	902	902	902	902	902
Task Behavioral health services are co-located within PCMH/APC practices and are available.	130	130	130	130	130	130	130	130	130	130
Task 1 Survey and group all participating providers (safety net and non safety net) into level of readiness.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness.										
Task 3 Clinical governance committee approves partner assessment results and PCMH roadmap.										
Task 4 Develop education program and schedule for each provider readiness category that includes support from PPS (internal) or with potential PCMH vendors (external).										
Task 5 Implement plan.										
Task 6 Monitor weekly, monthly, quarterly progress against PCMH / EHR-MU work plan goals.										
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.										
Task 1 In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.										
Task 2 Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices.										
Task 3 Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc.										
Task 4 Develop procedures to implement evidence based protocols with prescribed assessment tools including PHQ2/9, GAD, DAST, Audit C and SBIRT, stepped care, care team meetings, number of prescribers, etc.										
Task 5 Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers.										
Task 6 Establish Care teams within the practice to include care coordination to follow patients and provide "warm handoffs"										
Task 7 Establish procedure for "warm handoffs"										
Task 8 In accordance with evidence based care protocols, implement process for medication prescribing and management. The process will delineate one prescriber process.										
Task 9 Develop processes and procedures for care coordinators and care managers to engage in patient treatment as per protocols.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										

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Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	902	902	902	902	902	902	902	902	902	902
Task 1 Integrate assessment tools, PHQ2/9, DAST, Audit C and GAD into EMR for ease of access, and tracking and, monitoring										
Task 2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, Audit C, DAST for all patients. Set as mandatory fields within EMR whenever possible.										
Task 3 Implement SBIRT as per established, implemented protocols.										
Task 4 Create processes for referral and "warm handoffs". Process to include availability of BH provider at time service is needed and referred by PCP. BH provider will allow for add -ins to schedule as necessary for "warm handoffs" from PCP										
Task 5 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of "warm handoff" as well as monitoring the hand off.										
Task 6 Allow creation within EMR of separate encounter for each provider, PCP and BH, on the same day within single patient record and single billing claim record.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR.										
Task 2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.										
Task 3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.										
Task 4 Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.										
Task 5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP platforms, interfaces, and others.										
Milestone #5 Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	632	902	902	902	902	902	902	902	902	902
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	13	13	13	13	13	13	13	13	13	13
Task 1 Provide office space and staff for provision of full primary care services										
Task 2 Contract with EMR to ensure functionality provides for scheduling for both provider types within the same EMR where patient has a single record.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 3 Contract with EMR to add PCP licenses and templates for full documentation capabilities within the EMR and ensure a single repository of health information and data sharing amongst providers.										
Task 4 Partner with EMR vendor to ensure that security features are activated to ensure patient privacy and confidentiality of secure notes.										
Task 5 Ensure that confidentiality agreements are in place between providers for data use and exchange of information.										
Task 6 Develop and implement processes for physical medicine assessments within the BH workflow to identify potential health problems and provide early intervention, disease prevention and higher quality of care for BH patients										
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.										
Task 1 In conjunction with physician leads, Develop evidence based protocols in accordance with SAHMSA guidelines which include assessment tools to be implemented, medication management, and care coordination.										
Task 2 Establish formal meeting schedules amongst collaborating partners to establish collaborative care and best practices.										
Task 3 Determine who needs to attend formal meetings - BH specialists, Primary Care, Substance Use Disorder, Developmentally Disabled providers, etc.										
Task 4 Implement evidence based protocols with prescribed assessment tools, SBRIT, stepped care, care team meetings, number of prescribers, etc.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 5 Develop monitoring parameters to evaluate adherence to evidence based protocols. These will include metrics showing use of assessment tools, medications prescribed, referrals made and number of prescribers.										
Task 6 Establish Care teams within the practice to include care coordination to follow patients and provide "warm handoffs"										
Task 7 Establish procedure for "warm handoffs".										
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	902	902	902	902	902	902	902	902	902	902
Task 1 Integrate assessment tools, PHQ2/9, DAST and GAD into EMR for ease of access and tracking, monitoring.										
Task 2 Create automation within EMR to prompt completion of assessments, PHQ2/9, GAD, DAST for all patients. Set mandatory fields within EMR whenever possible.										
Task 3 Implement SBRIT as per established, implemented protocols										
Task 4 Define protocols for screening for physical illness. Screenings to include illnesses such as Diabetes, Cardiovascular disease, Cancer screenings, etc. as well as implement other illness preventions such as immunizations.										
Task 5 Create processes for "warm handoffs". Process to include										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
availability of BH provider at time service is needed and referred by PCP. BH provider will allow for ad ins to schedule as necessary for PCP "warm handoffs"										
Task 6 Integrated, single EMR will serve as repository of information and scheduler for both PCP and BH provider. Access to schedules shall be shared amongst staff for ease of encounter creation and facilitation of "warm handoff" as well as monitoring the hand off.										
Task 7 Allow creation within EMR of separate encounter for each provider, PCP and BH, on the same day within single patient record and single billing claim record.										
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Partner with EMR vendors to ensure that assessments are available in structured format within EMR and all patient data and assessments are documented and trackable in EHR										
Task 2 Utilize meaningful use dashboards and platforms as well as PCMH level capabilities to allow and provide tracking of assessments and assessment results.										
Task 3 Ensure that EHR has ability to create encounters for two different providers on the same day within the same patient record. Patient encounter data must be integrated and accessible to treating providers to increase efficiency and decrease duplication and error.										
Task 4 Create processes to pull reports from patient registry, PCMH capabilities, MU dashboards to identify target patients based on assessment tools implemented and assessment tool results.										
Task 5 Develop processes to generate reports showing assessment results to compare and track actively engaged patient outcomes and compliance. Reports may be obtained using MU dashboards, patient registries, PCMH capabilities, ACP										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
platforms, interfaces, and others										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	902	902	902	902	902	902	902	902	902	902
Task 1 In conjunction with physician leads and in accordance with SAHMSA guidelines develop evidence based protocols for the evaluation and treatment of Behavioral health conditions by the Primary cAre Provider consistent with IMPACT model of integrated care. Protocol also includes GAD, DAST, Audit C assessments and includes SBIRT, stepped care and quadrant clinical care.										
Task 2 Deploy physician engagement team to PCP practices to engage PCPs, distribute and train on evidence based protocol and secure commitment of PCP in the implementation of IMPACT.										
Task 3 Through Physician engagement meetings provide a forum for PCPs to learn about IMPACT, receive protocols and review processes.										
Task 4 Incorporate assessment tools, PHQ2/9, GAD, Audit C and DAST into practice EMR.										
Task 5 Employ assessment tools in EMR on all patients at PCP visits and SBIRT to identify patients in need of care early and provide intervention.										
Task 6 Hire and train Depression care managers to provide services consistent with IMPACT model of care at PCP sites.										
Task 7 Develop and implement process and procedures for assigning Care managers.										
Task 8 Develop and implement processes and timelines by which Depression care manager will engage, evaluate and implement treatment plan with patient										
Task 9 Develop communications process between Depression care Manager and PCP.										
Task 10 Develop communications process between Depression Care										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
manager and supervising psychiatrist.										
Task 11 Develop and implement process by which Depression care manager will document follow ups and patient encounters, treatment adjustments and/or compliance within the PCP's EMR.										
Task 12 Develop processes to connect with the different provider types within the ACP Care Teams to provide complete care to patients for all aspects of care. These processes shall include Integrated Delivery System and the use of the ACP care managers and care coordinators to monitor referrals, services and ensure timely delivery of services to patients.										
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Task 1 Develop processes to implement collaborative care standards as required in ACP evidence based protocols.										
Task 2 Create policies and procedures for engaging patients and assigning care team member, depression Care manager.										
Task 3 Create processes per evidence based protocols for implementation of care including single prescriber, stepped care consistent with IMPACT model.										
Task 4 Hire, train and deploy Depression care managers to provide care for engaged patients in collaboration with PCP and IMPACT model										
Task 5 Develop processes for creating a secure data repository to be accessed by supervising psychiatrist for monitoring and evaluation of the efficacy of care in accordance with IMPACT model.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 6 Develop process for assigning supervising psychiatrist.										
Task 7 Establish care team meeting schedules for review of treatment plans with Care managers and PCPs as well as care coordinators as needed.										
Task 8 Establish processes for continuous open lines of communication between PCP and care manager.										
Task 9 Establish clear process per evidence based protocol for consulting with Psychiatrist. When consult from psychiatrist is required and completed, psychiatrist will provide treatment recommendations and the single prescriber will remain the PCP in order to maintain the integrity of the IMPACT model.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Task 1 ACP will hire and deploy depression care managers in accordance with the IMPACT model. The Depression Care manager will assist the PCP in implementing treatment plans, counseling and will monitor progress, medication refills and adjustment as adjusted by the prescribing provider.										
Task 2 Develop process and procedures for Depression care manager to access and work with Care coordinators to coordinate services for patients including social supports, home care, specialty services, etc.										
Task 3 Develop ACP Care Manager training materials to Educate and train depression Care managers on ACP's referral processes and network Regional Care team providers, level of services available and accessibility to ensure that Care managers are familiar with ACP partners and their services in order to provide										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
patients timely and efficient access to care.										
Task 4 Develop programs for continuing education for depression care managers to assist in providing and maintaining high standards of care to patients in implementation of care and treatment plans.										
Task 5 Develop training manuals for depression care manager on EMRs used at PCP practices for documentation of all services and assessments within the single EMR. Training will be concise and focused on documenting all encounters, assessments and treatment plans in a format amenable to extracting data for metrics and performance reporting.										
Task 6 Develop depression care manager roles and responsibilities to include all services to be provided to patient in accordance with IMPACT model care guidelines.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task 1 Engage psychiatrists and establish service agreements with ACP network psychiatrists to provide supervision of treatment plans and assessments consistent with the IMPACT model such as with Dr. Fernando Taveras and Dr. Rodney Campos, amongst others.										
Task 2 Create a secure site for repository of information to be accessed by psychiatrists. Site will hold treatment and assessment note on patients engaged in the IMPACT model which will be evaluated by supervising psychiatrist assigned to the patient.										
Task 3 Develop a process for assigning patients to designated psychiatrist. Designations will be based primarily on patient's language, culture and relationship with the PCP and the community being served. This criteria will allow for a greater understanding of the patient's social conditions as well as a greater chance of compliance if psychiatrist face to face consult is required at a later time.										
Task 4 Develop process by which Depression Care manager uploads patient information into Psychiatrist's secure site.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task 1 Incorporate assessment tools, ie. PHQ9 into PCP's EMR										
Task 2 Implement procedures for periodic repeat assessments in accordance with stepped care prescribed in evidence based protocol performed by the Depression care manager within the PCP's EMR.										
Task 3 Work with EMR vendors to Create filters and reportable fields that will allow the extrapolating of assessment data. ACP will rely on reportable data from MU dashboards, PCMH data fields, patient registries and others.										
Task 4 Use PCP's EMR to extrapolate comparison data, flow sheets to establish trends in symptoms based on assessment responses and measure outcomes.										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Task 1 Implement Stepped care in accordance with ACP evidence based protocol, patients with positive PHQ9 values requiring treatment shall be treated as per specified treatment options and in stepped care by the PCP										
Task 2 Process is created for assignment of patient to Depression care manager for continuity of care and monitoring.										
Task 3 Process is created for continuous open lines of communication between Depression care manager and PCP, and on site care team as necessary.										
Task 4 In line with stepped care, Depression Care manager performs follow up PHQ9 assessment in intervals to ascertain effectiveness of treatment and make appropriate adjustments										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
after consulting with PCP.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Working with EMR vendors, assessment tools are incorporated within EMRs in a format that is reportable in which data is ascertainable.										
Task 2 Develop process for extrapolating and reporting data to track and monitor all engaged patients.										
Task 3 Create FTP secure site and or other IDS platform for providing data to supervising psychiatrist and exchanging information.										
Task 4 Create connection and interfaces with other platforms including Care coordination/management platform, ACP IDS for open efficient exchange of information and more effective patient care.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Provide "stepped care" as required by the IMPACT Model.	jd593813	Other	25_PMDL3703_1_3_20160315232145_3ai_14_-_IMPACT_Model_Stepped_Care.pdf	Remediation response to 3ai PCP-BH Integration Milestone 14 - description of Stepped Care under IMPACT Model starts on page 9.	03/15/2016 11:21 PM
	jd593813	Other	25_PMDL3703_1_3_20160203164717_PCP-BH_Integration_14.1-14.4.docx	PCP-BH Integration File Upload Proxy	02/03/2016 04:47 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	1.1 ACP Providers have been surveyed and categorized as non-PCMH certified, current PCMH certified, and paper providers. Each category will indicate a level of readiness for PCMH transformation/actualization. 1.2 ACP has partnered with vendors that will serve as resources for practice transformations by following the ACP Implementation plan for each provider

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	category type.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	2.2-2.3 Meeting schedules are monthly (physician engagement, PAC, care teams, clinical quality committees).
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.	3.2 EMR prompts in place (order sets, CDSS) to administer screening tools.
Use EHRs or other technical platforms to track all patients engaged in this project.	4.5 'How to's' developed that show how to pull reports in EHRs to assist with patient engagement tracking.
Co-locate primary care services at behavioral health sites.	5.5 Participating provider agreements contain data exchange and confidentiality clauses. 5.6 Workflow integration developed.
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	7.2 EHRs contain automated process (order sets, CDSS) to administer screening tools.
Use EHRs or other technical platforms to track all patients engaged in this project.	8.5 Registries and centralized reporting processes established to track and identify engaged patients.
Implement IMPACT Model at Primary Care Sites.	9.2 Protocols disseminated and physicians have been trained. 9.6, 9.8 Depression Care Manual completed by ACP and approved by NYS OMH Department of Collaborative Care.
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	5.5 sFTP site created as a repository for monitoring care plans 5.6-5.8 Supervising psychiatrist assignment process developed. Communications process established.
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	11.3 and 11.5 Training materials developed 11.6 Roles and responsibilities developed
Designate a Psychiatrist meeting requirements of the IMPACT Model.	12.1 Psychiatrists engaged and agreements in place 12.2 sFTP site in place to securely store and exchange information 12.3 Patient assignment process developed 12.4 sFTP site process for upload and download of information established
Measure outcomes as required in the IMPACT Model.	
Provide "stepped care" as required by the IMPACT Model.	14.1-14.4 Depression Care Manual completed by ACP and approved by NYS OMH Department of Collaborative Care.
Use EHRs or other technical platforms to track all patients engaged in this project.	

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Complete	
Milestone #15	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 3.b.i – Evidence-based strategies for disease management in high risk/affected populations (adult only)

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

Instructions :

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

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

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	319,171

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
111,709	150,969	94.60%	8,616	47.30%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (159,585)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
jd593813	Rosters	25_PMDL4215_1_3_20160203165957_CV_Patient_Engagement.xlsx	Patient Engagement File	02/03/2016 05:00 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

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

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 5 Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 7 Implement Million hearts campaign	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 8 Care Teams are created regionally and information distributed to all PPS partners in order to better coordinate care and provide efficient services.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 9 Create Care Coordination/Care Management back office to assist in managing referrals, treatment plan adherence and coordinating social services as appropriate	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Partner with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.									
Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4 Develop other interim solutions for sharing health information among clinical partners using direct excpatient record lookup. Determine other needs or enhancements based on IT/integration gap analyses. 04/01/2015-12/31/2015	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 7 Develop final plan for sharing health information among clinical partners by DY3.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.	Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

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Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Create "how to" training tools to be provided at the practice level for simplified physician and staff training in order to	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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increase compliance and correct collection of data for monitoring engagement and performance.									
Task 3 Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as BP levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Organize tobacco assessment tools within the EMR and create mandatory fields where the provider is prompted and obligated to record tobacco use assessment and counseling for users. Leverage meaningful use requirements and systems to assist in these prompts.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Create evidence based protocols for tobacco use cessation incorporating the 5 A's.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 3 Distribute protocols and train practices on documentation and process within the protocols and how to use the assessment tools. Protocol shall be distributed in physician engagement meetings, by provider engagement tem, and in electronic forms. Provider engagement teams will provide training on processes and implementation to these at onsite visits and trainings. The provider engagement team visits will be ongoing and used to	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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provide periodic trainings and updates on protocols, processes and updates.									
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 1 Develop/create evidence based protocols for Cardio vascular disease to include evaluation and treatment of hyperlipidemia as approved by ACP physician leads in accordance with JNC-8, American Heart Association, and USPSTF.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Leverage existing physician groups to reach and obtain "buy in" of physician partners in ACP protocols and processes.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 3 Use provider engagement teams, physician engagement meetings, Care Teams to establish rapport with providers and distribute and train in the adoption of the evidence based protocols and standards of care.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 ACP has provider participation agreements in place with its providers in which there is an acceptance as to following ACP processes including standards of care and metric reporting.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Task Care coordination processes are in place.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1 Establish ACP PMO back office central hub which includes team of care coordinators, care managers, community health workers, outreach staff.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2 Create training materials for patient education and self -management in different languages taking into consideration the language and culture of the target population.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Create Care Coordination processes and procedures	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Train back office staff in ACP care coordination processes in accordance with project requirements and project specific protocol implementation.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5 Train back office staff, care managers, care coordinators in patient self -management techniques as per the ACP created and disseminated patient self -management training materials. Staff will learn what the coordination requirements are as per the established protocols and ACP processes. They will learn Implementation of protocol specific techniques in language and culturally appropriate manner.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6 Establish Care Teams ensuring inclusion of pharmacists, nutritional counselors, and other ancillary providers including DME vendors, diagnostic entities, etc. that back office will coordinate	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7 Train back office staff care managers and care coordinators in lifestyle coaching and providing educational materials in language appropriate and culturally sensitive manner	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 8 Train and utilize Community health workers to approach and educate target populations to increase health literacy, self awareness and disease management and prevention.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9 Utilize community health workers to liaise with CBOs to hold	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Stanford Model educational seminars within the communities in a culturally sensitive and language appropriate forum.									
Task 10 Implement IDS consistent with project 2.a.i to have a integration of information centralized and accessible for more efficient and effective care. The IDS will utilize interfaces and connections for two way interchange of information between physician EMRs, hospital EMRs, CBOs and other entities all of which the central Care coordination teams will be able to access for follow up and follow through.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Provider	Practitioner - Primary Care Provider (PCP)	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 As required in ACP's protocol and processes, agreements are made with all PCPs that provide for the opportunity for patients to have BP monitored as walk ins, without appointments and without copay.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 PPS negotiates with MCOs to assure that no copays are deemed necessary for BP checks.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3 Process and procedure manual and agreement with PCPs to also stipulate need to fit patient into schedule to be seen by provider if BP values are at unacceptable levels.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1 Develop training manuals for training of office staff at all levels on proper technique and equipment use for accurate BP measurement. Training manual also to include acceptable and	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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non-acceptable values, to prompt staff to seek physician intervention upon attainment of unacceptable values.									
Task 2 Implement training to all staff regarding BP measurement. Provider engagement teams provide on-site training to practice staff on BP measurement manual and obtain staff training certifications to be provided to Workforce office for monitoring and reporting.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Develop data pull frequencies to utilize EMR patient registries to identify blood-pressure values.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Create analytics tool to cross analyze BP values against those with Cardiovascular diagnosis, ie diagnosis of Hypertension and number of encounters with elevated blood-pressure values.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Create process for reporting to Central hub and to PCP findings of analytics report.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Create process for receiving patient data for those identified via the data analysis and providing outreach to these patients to schedule for PCP visit and early intervention. Outreach may be provided at the central level via community health workers if needed or at the local level by the PCP office when patient is reachable and known to them.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Task 5 Processes for identification and periodicity of visits to be updated periodically, and minimally yearly by Clinical Quality Committee and staff retraining to be repeated as necessary, minimally yearly to keep up to date on process updates.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 1 Implement ACP evidence based CV protocol created in accordance with JNC recommendations, which calls for once daily regimens and includes preferential drugs as appropriate in a format that is user friendly and understandable.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Train physicians on implementation of evidence based protocols treatment plans and provide assistance and follow up.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Clinical Quality Committee Review CV evidence based protocols periodically and minimally yearly to revise and update as per latest advances and recommendations.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Self-management goals are documented in the clinical record.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 As per evidence based protocols, train providers on setting self-management goals for the individual patient. Self-management goals may be updated as per updated protocols upon review by the Clinical Quality Committee.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Provide training to staff on monitoring the patient's progress on	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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self-management goal as per set goals according to protocols. Re-Training will be periodic and minimally yearly, though may be sooner if protocol needs updating.									
Task 3 Work with EMR vendors to Create and Provide structured data fields within the EMRs where self-management goals can be easily identified and progress on such can be reportable.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4 Train providers and staff on entering self-management goals data entering and monitoring.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has developed referral and follow-up process and adheres to process.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Engage PCPs and train on and implement cardiovascular (CV) evidence based protocols ensuring attention to identification of behavioral health status and referral criteria.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Create protocol and processes for realization of "warm handoffs" when patients identified as needing behavioral health services. Utilize physician engagement team to implement and train staff at PCP office on "warm handoffs" of patients needing behavioral health services.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Provide PCPs with care teams' information and referral processes for providing referrals to and receiving information from CBOs, Behavioral and Mental health partners.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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4 Establish central back office inclusive of care coordinators, care managers, community health workers and outreach staff with interfaces and two way connections that allow for upload of referrals as they are created by partners and as they are processed.									
Task 5 Establish and implement processes by which care coordinators receive and follow referrals as they are uploaded into Care management system electronically.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6 Establish and implement process and procedures by which care coordinators intervene in assisting patients in coordinating needed services from the full range of ACP partner providers and community based organizations, local government and specialty agencies.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7 Establish process by which care coordinator central or at the practice site ensures receipt of services by patient and marks to send back to referring provider the result and outcome of services received by patient using.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8 Develop and implement procedures for warm handoffs as in previous tasks.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9 Establish periodicity of staff retraining to ensure comprehension and adherence to processes. Retraining to be minimally yearly but optimally twice yearly.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 10 Perform analysis of CNA to determine community resources available.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 11 Perform network analysis to determine size and scope of necessary resources	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 12 Draft CBO agreements and present to Board for approval. The CBO agreements will include services to be provided, timeliness of provision of services, ability and commitment to timely information exchange.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Task 13 Utilize Community Engagement teams to Distribute RFP to CBOs to evaluate services, timeliness of services and CBO's capacity.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 14 Utilize Community Engagement team to establish rapport, present formal agreements and obtain signed formal agreements.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Project	N/A	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 1 Develop training manual for patients on how to measure BP. The manual includes proper technique and equipment use. The manual also contains guidance on values and goals with instruction on alert values and how to document the values.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Distribute BP manual to all practices for implementation and release to patients.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Engage physicians and their staff in implementation of manual and training the patient. The physician engagement team shall provide in-house training to physicians and all practice staff on how to use the training manual and how to train the patient on proper BP measuring.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Processes are put in place at PCP offices for staff to accept and evaluate patient's BP logs which the patient shall bring to every visit.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

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Task 5 Staff is trained as per BP manual on evaluating equipment. BP levels measured at PCP office with patient equipment may be compared to readings at PCP office using office equipment.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Establish process for monthly data pulls from EMR registries for all patients with Hypertensive Cardiovascular disease by ICD code	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Create filters for cross reference of reports pulled from EMR registries with parameters for all patients with hypertensive CV disease by ICD code/ date of last encounter/ and date of next visit. Identify all patients without a follow up appointment or who skipped a scheduled encounter.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Establish process for outreach to target patients and schedule a prompt appointment. PCPs allow for timely scheduling of the appointments.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Establish process for staff to communicate to CHWs patient lists/rosters who miss more than one appointment or are not reachable. CHW will provide services within the community and work to find the patient and connect the patient back to the PCP.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task PPS has developed referral and follow-up process and adheres to process.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1 Establish procedures in accordance with evidence based protocols for referrals of tobacco users to NYS Smoker's Quitline.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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2 Implement process for care coordinators and CHWs to receive and access referrals and follow up to ensure compliance and assist in care plan.									
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1 Perform CNA analysis to determine "hot spots". Determine neighborhoods with highest risk.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3 Utilize EMR technology to gather pertinent information. Activate features within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5 As in previous tasks, Utilize community health workers to identify and establish agreements with CBOs that will then serve	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
for implementation of Stanford model.									
Milestone #18 Adopt strategies from the Million Hearts Campaign.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Mental Health	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 With physician leads, Create ACP Million Hearts Campaign implementation and training materials.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2 Distribute Million Hearts Campaign implementation materials to all PCPs at physician engagement meetings, in person by Physician engagement team member, electronically.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 3 Physician engagement team to provide PCPs training on million hearts campaign implementation to include BP checks without appointments, without copays, staff training and re-training and identifying a designated BP check area.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4 Working with community enterprises, organizations, MCOs and Physicians; ACP's Community Engagement team will negotiate and create patient compliance incentives to assist in motivating patients to adhere to treatment plans	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5 Develop processes in accordance with million hearts campaign including patient self-management educational materials to be distributed to target patients and training provided at point of care in provider office.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6 Develop patient training and educational materials for patient	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

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PPS has engaged at least 80% of their PCPs in this activity.		Care Provider (PCP)							
Task 1 Leverage relationships within physician groups, IPAs, etc to engage physicians in ACP values.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Working with the finance department, formulate incentives for PCP participation.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3 Through physician engagement meetings, physician engagement teams, physician champions and other relationships; foster tight relationships with physicians and obtain agreements of participation with at least 80% of PCPs in ACP's network.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task 1 Working with physician leads and in accordance to American Heart Association and the JNC-8 recommendations and incorpoarating the guidelines of the US Preventive Services Task Force (USPSTF), develop evidence based protocol for the identification and management of cardiovascular disease and hyperlipidemia in the ambulatory practice.										
Task 2 Based on protocol guidelines for evaluation, create a reporting system using EMR registries to identify target patients, ie. Blood Pressure readings, Cholesterol levels.										
Task 3 Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and educational services as needed.										

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Task 4 Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members. Protocols is also be made distributed electronically to every provider.										
Task 5 Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.										
Task 6 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.										
Task 7 Implement Million hearts campaign										
Task 8 Care Teams are created regionally and information distributed to all PPS partners in order to better coordinate care and provide efficient services.										
Task 9 Create Care Coordination/Care Management back office to assist in managing referrals, treatment plan adherence and coordinating social services as appropriate										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	51	101	176
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	50	100	174
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	10	20	34
Task PPS uses alerts and secure messaging functionality.										
Task 1 Partner with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.										
Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.										
Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.										
Task 4 Develop other interim solutions for sharing health information among clinical partners using direct excpatient record lookup. Determine other needs or enhancements based on IT/integration gap analyses. 04/01/2015-12/31/2015										
Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.										
Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.										
Task 7 Develop final plan for sharing health information among clinical partners by DY3.										
Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.										
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	55	110	193
Task 1 Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.										

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Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).										
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.										
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.										
Task 2 Create "how to" training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.										
Task 3 Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as BP levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.										

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Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).										
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.										
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.										
Task 1 Organize tobacco assessment tools within the EMR and create mandatory fields where the provider is prompted and obligated to record tobacco use assessment and counseling for users. Leverage meaningful use requirements and systems to assist in these prompts.										
Task 2 Create evidence based protocols for tobacco use cessation incorporating the 5 A's.										
Task 3 Distribute protocols and train practices on documentation and process within the protocols and how to use the assessment tools. Protocol shall be distributed in physician engagement meetings, by provider engagement tem, and in electronic forms. Provider engagement teams will provide training on processes and implementation to these at onsite visits and trainings. The provider engagement team visits will be ongoing and used to provide periodic trainings and updates on protocols, processes and updates.										
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.										
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).										
Task 1 Develop/create evidence based protocols for Cardio vascular disease to include evaluation and treatment of hyperlipidemia as approved by ACP physician leads in accordance with JNC-8, American Heart Association, and USPSTF.										
Task 2 Leverage existing physician groups to reach and obtain "buy in" of physician partners in ACP protocols and processes.										
Task 3 Use provider engagement teams, physician engagement										

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meetings, Care Teams to establish rapport with providers and distribute and train in the adoption of the evidence based protocols and standards of care.										
Task 4 ACP has provider participation agreements in place with its providers in which there is an acceptance as to following ACP processes including standards of care and metric reporting.										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are in place.										
Task 1 Establish ACP PMO back office central hub which includes team of care coordinators, care managers, community health workers, outreach staff.										
Task 2 Create training materials for patient education and self -management in different languages taking into consideration the language and culture of the target population.										
Task 3 Create Care Coordination processes and procedures										
Task 4 Train back office staff in ACP care coordination processes in accordance with project requirements and project specific protocol implementation.										
Task 5 Train back office staff, care managers, care coordinators in patient self -management techniques as per the ACP created and disseminated patient self -management training materials. Staff will learn what the coordination requirements are as per the established protocols and ACP processes. They will learn Implementation of protocol specific techniques in language and culturally appropriate manner.										
Task 6 Establish Care Teams ensuring inclusion of pharmacists,										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
nutritional counselors, and other ancillary providers including DME vendors, diagnostic entities, etc. that back office will coordinate										
Task 7 Train back office staff care managers and care coordinators in lifestyle coaching and providing educational materials in language appropriate and culturally sensitive manner										
Task 8 Train and utilize Community health workers to approach and educate target populations to increase health literacy, self awareness and disease management and prevention.										
Task 9 Utilize community health workers to liaise with CBOs to hold Stanford Model educational seminars within the communities in a culturally sensitive and language appropriate forum.										
Task 10 Implement IDS consistent with project 2.a.i to have a integration of information centralized and accessible for more efficient and effective care. The IDS will utilize interfaces and connections for two way interchange of information between physician EMRs, hospital EMRs, CBOs and other entities all of which the central Care coordination teams will be able to access for follow up and follow through.										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	0	110	357	549	549	549	549	549	549	549
Task 1 As required in ACP's protocol and processes, agreements are made with all PCPs that provide for the opportunity for patients to have BP monitored as walk ins, without appointments and without copay.										
Task 2 PPS negotiates with MCOs to assure that no copays are deemed necessary for BP checks.										
Task 3 Process and procedure manual and agreement with PCPs to also stipulate need to fit patient into schedule to be seen by provider if BP values are at unacceptable levels.										
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.										

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Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.										
Task 1 Develop training manuals for training of office staff at all levels on proper technique and equipment use for accurate BP measurement. Training manual also to include acceptable and non-acceptable values, to prompt staff to seek physician intervention upon attainment of unacceptable values.										
Task 2 Implement training to all staff regarding BP measurement. Provider engagement teams provide on-site training to practice staff on BP measurement manual and obtain staff training certifications to be provided to Workforce office for monitoring and reporting.										
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.										
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.										
Task 1 Develop data pull frequencies to utilize EMR patient registries to identify blood-pressure values.										
Task 2 Create analytics tool to cross analyze BP values against those with Cardiovascular diagnosis, ie diagnosis of Hypertension and number of encounters with elevated blood-pressure values.										
Task 3 Create process for reporting to Central hub and to PCP findings of analytics report.										
Task 4 Create process for receiving patient data for those identified via the data analysis and providing outreach to these patients to schedule for PCP visit and early intervention. Outreach may be provided at the central level via community health workers if needed or at the local level by the PCP office when patient is										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
reachable and known to them.										
Task 5 Processes for identification and periodicity of visits to be updated periodically, and minimally yearly by Clinical Quality Committee and staff retraining to be repeated as necessary, minimally yearly to keep up to date on process updates.										
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										
Task 1 Implement ACP evidence based CV protocol created in accordance with JNC recommendations, which calls for once daily regimens and includes preferential drugs as appropriate in a format that is user friendly and understandable.										
Task 2 Train physicians on implementation of evidence based protocols treatment plans and provide assistance and follow up.										
Task 3 Clinical Quality Committee Review CV evidence based protocols periodically and minimally yearly to revise and update as per latest advances and recommendations.										
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task 1 As per evidence based protocols, train providers on setting self-management goals for the individual patient. Self-management goals may be updated as per updated protocols upon review by the Clinical Quality Committee.										
Task 2 Provide training to staff on monitoring the patient's progress on self-management goal as per set goals according to protocols. Re-Training will be periodic and minimally yearly, though may be sooner if protocol needs updating.										

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DSRIP Implementation Plan Project

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 3 Work with EMR vendors to Create and Provide structured data fields within the EMRs where self-management goals can be easily identified and progress on such can be reportable.										
Task 4 Train providers and staff on entering self-management goals data entering and monitoring.										
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.										
Task 1 Engage PCPs and train on and implement cardiovascular (CV) evidence based protocols ensuring attention to identification of behavioral health status and referral criteria.										
Task 2 Create protocol and processes for realization of "warm handoffs" when patients identified as needing behavioral health services. Utilize physician engagement team to implement and train staff at PCP office on "warm handoffs" of patients needing behavioral health services.										
Task 3 Provide PCPs with care teams' information and referral processes for providing referrals to and receiving information from CBOs, Behavioral and Mental health partners.										
Task 4 Establish central back office inclusive of care coordinators, care managers, community health workers and outreach staff with interfaces and two way connections that allow for upload of referrals as they are created by partners and as they are processed.										
Task 5 Establish and implement processes by which care coordinators receive and follow referrals as they are uploaded into Care management system electronically.										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 6 Establish and implement process and procedures by which care coordinators intervene in assisting patients in coordinating needed services from the full range of ACP partner providers and community based organizations, local government and specialty agencies.										
Task 7 Establish process by which care coordinator central or at the practice site ensures receipt of services by patient and marks to send back to referring provider the result and outcome of services received by patient using.										
Task 8 Develop and implement procedures for warm handoffs as in previous tasks.										
Task 9 Establish periodicity of staff retraining to ensure comprehension and adherence to processes. Retraining to be minimally yearly but optimally twice yearly.										
Task 10 Perform analysis of CNA to determine community resources available.										
Task 11 Perform network analysis to determine size and scope of necessary resources										
Task 12 Draft CBO agreements and present to Board for approval. The CBO agreements will include services to be provided, timeliness of provision of services, ability and commitment to timely information exchange.										
Task 13 Utilize Community Engagement teams to Distribute RFP to CBOs to evaluate services, timeliness of services and CBO's capacity.										
Task 14 Utilize Community Engagement team to establish rapport, present formal agreements and obtain signed formal agreements.										
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.										
Task PPS has developed and implemented protocols for home blood pressure monitoring.										
Task PPS provides follow up to support to patients with ongoing blood										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task 1 Develop training manual for patients on how to measure BP. The manual includes proper technique and equipment use. The manual also contains guidance on values and goals with instruction on alert values and how to document the values.										
Task 2 Distribute BP manual to all practices for implementation and release to patients.										
Task 3 Engage physicians and their staff in implementation of manual and training the patient. The physician engagement team shall provide in-house training to physicians and all practice staff on how to use the training manual and how to train the patient on proper BP measuring.										
Task 4 Processes are put in place at PCP offices for staff to accept and evaluate patient's BP logs which the patient shall bring to every visit.										
Task 5 Staff is trained as per BP manual on evaluating equipment. BP levels measured at PCP office with patient equipment may be compared to readings at PCP office using office equipment.										
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task 1 Establish process for monthly data pulls from EMR registries for all patients with Hypertensive Cardiovascular disease by ICD code										
Task 2 Create filters for cross reference of reports pulled from EMR registries with parameters for all patients with hypertensive CV disease by ICD code/ date of last encounter/ and date of next visit. Identify all patients without a follow up appointment or who skipped a scheduled encounter.										
Task 3 Establish process for outreach to target patients and schedule										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
a prompt appointment. PCPs allow for timely scheduling of the appointments.										
Task 4 Establish process for staff to communicate to CHWs patient lists/rosters who miss more than one appointment or are not reachable. CHW will provide services within the community and work to find the patient and connect the patient back to the PCP.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task 1 Establish procedures in accordance with evidence based protocols for referrals of tobacco users to NYS Smoker's Quitline.										
Task 2 Implement process for care coordinators and CHWs to receive and access referrals and follow up to ensure compliance and assist in care plan.										
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task 1 Perform CNA analysis to determine "hot spots". Determine neighborhoods with highest risk.										
Task 2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 3 Utilize EMR technology to gather pertinent information. Activate features within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.										
Task 4 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.										
Task 5 As in previous tasks, Utilize community health workers to identify and establish agreements with CBOs that will then serve for implementation of Stanford model.										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	110	247	467	549	549	549	549	549	549
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	286	643	1,214	1,428	1,428	1,428	1,428	1,428	1,428
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	26	59	111	130	130	130	130	130	130
Task 1 With physician leads, Create ACP Million Hearts Campaign implementation and training materials.										
Task 2 Distribute Million Hearts Campaign implementation materials to all PCPs at physician engagement meetings, in person by Physician engagement team member, electronically.										
Task 3 Physician engagement team to provide PCPs training on million hearts campaign implementation to include BP checks without appointments, without copays, staff training and re-training and identifying a designated BP check area.										
Task 4 Working with community enterprises, organizations, MCOs and Physicians; ACP's Community Engagement team will negotiate and create patient compliance incentives to assist in motivating patients to adhere to treatment plans										
Task 5 Develop processes in accordance with million hearts campaign										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
including patient self-management educational materials to be distributed to target patients and training provided at point of care in provider office.										
Task 6 Develop patient training and educational materials for patient disease self-management techniques including how to monitor and record blood pressure levels at home.										
Task 7 Develop Lifestyle modification teaching and training materials including nutritional counseling.										
Task 8 In accordance with Million Hearts Campaign, Develop staff retraining tools and manuals and use provider engagement team to provide individual practice's staff members retraining on how to monitor blood pressures to ensure that patients can walk in to the practice and have their BP checked by any staff member at any time. The process will ensure that each staff member knows the correct technique and value assessment at the time that the patient comes in and is trained on the process to bring out of range values to the immediate attention of the provider.										
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task 1 Leverage existing relationships with MCOs to negotiate extended coverage for target and affected population. The negotiating to include coverage for items such as BP machines for every patient with Hypertension, Nutritional counseling, smoking cessation medications and counseling as well as others.										
Task 2 Utilize existing relationships to negotiate and form agreements with MCOs by which copays are waived for BP check exams.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	110	247	384	549	549	549	549	549	549
Task 1 Leverage relationships within physician groups, IPAs, etc to										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
engage physicians in ACP values.										
Task 2 Working with the finance department, formulate incentives for PCP participation.										
Task 3 Through physician engagement meetings, physician engagement teams, physician champions and other relationships; foster tight relationships with physicians and obtain agreements of participation with at least 80% of PCPs in ACP's network.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task 1 Working with physician leads and in accordance to American Heart Association and the JNC-8 recommendations and incorpoarating the guidelines of the US Preventive Services Task Force (USPSTF), develop evidence based protocol for the identification and management of cardiovascular disease and hyperlipidemia in the ambulatory practice.										
Task 2 Based on protocol guidelines for evaluation, create a reporting system using EMR registries to identify target patients, ie. Blood Pressure readings, Cholesterol levels.										
Task 3 Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and educational services as needed.										
Task 4 Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members. Protocols is also be made distributed electronically to every provider.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 5 Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.										
Task 6 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.										
Task 7 Implement Million hearts campaign										
Task 8 Care Teams are created regionally and information distributed to all PPS partners in order to better coordinate care and provide efficient services.										
Task 9 Create Care Coordination/Care Management back office to assist in managing referrals, treatment plan adherence and coordinating social services as appropriate										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	351	501	501	501	501	501	501	501	501	501
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	348	496	496	496	496	496	496	496	496	496
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	68	96	96	96	96	96	96	96	96	96
Task PPS uses alerts and secure messaging functionality.										
Task 1 Partner with eClinical Works, MDLand and other major EHR vendors to establish bi-directional EHX platform to share information among PPS safety net partners who use eClinical Works EHR. The strategy around this milestone will directly mimic what we have in place for project 2ai.										
Task 2 Establish work plans with hospital partners to develop Admission / Discharge / Transfer (ADT) feeds into HIE.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 3 Establish work plans with eClinical Works, MDLand and other major EHR vendors among ACP participating safety net providers for data feed into HIE platform.										
Task 4 Develop other interim solutions for sharing health information among clinical partners using direct excpatient record lookup. Determine other needs or enhancements based on IT/integration gap analyses. 04/01/2015-12/31/2015										
Task 5 Connect with RHIO/QE and develop plan on sharing health information as the State makes the information available.										
Task 6 Obtain and understand DSRIP policies, procedures and processes with respect to RHIO/SHIN-NY requirements as the information becomes available.										
Task 7 Develop final plan for sharing health information among clinical partners by DY3.										
Task 8 Ensure compliance with data sharing and confidentiality rules are followed with every data sharing event. This includes appropriate securities and encryption methodologies are in place to comply with HIPAA and other state and federal guidelines regarding PHI.										
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	385	549	549	549	549	549	549	549	549	549
Task 1 Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
providers who are still utilizing paper medical records).										
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.										
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.										
Task 2 Create "how to" training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.										
Task 3 Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as BP levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.										
Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).										
Task PPS has implemented an automated scheduling system to										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
facilitate tobacco control protocols.										
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.										
Task 1 Organize tobacco assessment tools within the EMR and create mandatory fields where the provider is prompted and obligated to record tobacco use assessment and counseling for users. Leverage meaningful use requirements and systems to assist in these prompts.										
Task 2 Create evidence based protocols for tobacco use cessation incorporating the 5 A's.										
Task 3 Distribute protocols and train practices on documentation and process within the protocols and how to use the assessment tools. Protocol shall be distributed in physician engagement meetings, by provider engagement tem, and in electronic forms. Provider engagement teams will provide training on processes and implementation to these at onsite visits and trainings. The provider engagement team visits will be ongoing and used to provide periodic trainings and updates on protocols, processes and updates.										
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.										
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).										
Task 1 Develop/create evidence based protocols for Cardio vascular disease to include evaluation and treatment of hyperlipidemia as approved by ACP physician leads in accordance with JNC-8, American Heart Association, and USPSTF.										
Task 2 Leverage existing physician groups to reach and obtain "buy in" of physician partners in ACP protocols and processes.										
Task 3 Use provider engagement teams, physician engagement meetings, Care Teams to establish rapport with providers and distribute and train in the adoption of the evidence based protocols and standards of care.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 4 ACP has provider participation agreements in place with its providers in which there is an acceptance as to following ACP processes including standards of care and metric reporting.										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are in place.										
Task 1 Establish ACP PMO back office central hub which includes team of care coordinators, care managers, community health workers, outreach staff.										
Task 2 Create training materials for patient education and self -management in different languages taking into consideration the language and culture of the target population.										
Task 3 Create Care Coordination processes and procedures										
Task 4 Train back office staff in ACP care coordination processes in accordance with project requirements and project specific protocol implementation.										
Task 5 Train back office staff, care managers, care coordinators in patient self -management techniques as per the ACP created and disseminated patient self -management training materials. Staff will learn what the coordination requirements are as per the established protocols and ACP processes. They will learn Implementation of protocol specific techniques in language and culturally appropriate manner.										
Task 6 Establish Care Teams ensuring inclusion of pharmacists, nutritional counselors, and other ancillary providers including DME vendors, diagnostic entities, etc. that back office will coordinate										

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Task 7 Train back office staff care managers and care coordinators in lifestyle coaching and providing educational materials in language appropriate and culturally sensitive manner										
Task 8 Train and utilize Community health workers to approach and educate target populations to increase health literacy, self awareness and disease management and prevention.										
Task 9 Utilize community health workers to liaise with CBOs to hold Stanford Model educational seminars within the communities in a culturally sensitive and language appropriate forum.										
Task 10 Implement IDS consistent with project 2.a.i to have a integration of information centralized and accessible for more efficient and effective care. The IDS will utilize interfaces and connections for two way interchange of information between physician EMRs, hospital EMRs, CBOs and other entities all of which the central Care coordination teams will be able to access for follow up and follow through.										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	549	549	549	549	549	549	549	549	549	549
Task 1 As required in ACP's protocol and processes, agreements are made with all PCPs that provide for the opportunity for patients to have BP monitored as walk ins, without appointments and without copay.										
Task 2 PPS negotiates with MCOs to assure that no copays are deemed necessary for BP checks.										
Task 3 Process and procedure manual and agreement with PCPs to also stipulate need to fit patient into schedule to be seen by provider if BP values are at unacceptable levels.										
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.										
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.										

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Task 1 Develop training manuals for training of office staff at all levels on proper technique and equipment use for accurate BP measurement. Training manual also to include acceptable and non-acceptable values, to prompt staff to seek physician intervention upon attainment of unacceptable values.										
Task 2 Implement training to all staff regarding BP measurement. Provider engagement teams provide on-site training to practice staff on BP measurement manual and obtain staff training certifications to be provided to Workforce office for monitoring and reporting.										
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.										
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.										
Task 1 Develop data pull frequencies to utilize EMR patient registries to identify blood-pressure values.										
Task 2 Create analytics tool to cross analyze BP values against those with Cardiovascular diagnosis, ie diagnosis of Hypertension and number of encounters with elevated blood-pressure values.										
Task 3 Create process for reporting to Central hub and to PCP findings of analytics report.										
Task 4 Create process for receiving patient data for those identified via the data analysis and providing outreach to these patients to schedule for PCP visit and early intervention. Outreach may be provided at the central level via community health workers if needed or at the local level by the PCP office when patient is reachable and known to them.										
Task 5 Processes for identification and periodicity of visits to be										

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updated periodically, and minimally yearly by Clinical Quality Committee and staff retraining to be repeated as necessary, minimally yearly to keep up to date on process updates.										
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.										
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.										
Task 1 Implement ACP evidence based CV protocol created in accordance with JNC recommendations, which calls for once daily regimens and includes preferential drugs as appropriate in a format that is user friendly and understandable.										
Task 2 Train physicians on implementation of evidence based protocols treatment plans and provide assistance and follow up.										
Task 3 Clinical Quality Committee Review CV evidence based protocols periodically and minimally yearly to revise and update as per latest advances and recommendations.										
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.										
Task Self-management goals are documented in the clinical record.										
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task 1 As per evidence based protocols, train providers on setting self-management goals for the individual patient. Self-management goals may be updated as per updated protocols upon review by the Clinical Quality Committee.										
Task 2 Provide training to staff on monitoring the patient's progress on self-management goal as per set goals according to protocols. Re-Training will be periodic and minimally yearly, though may be sooner if protocol needs updating.										
Task 3 Work with EMR vendors to Create and Provide structured data fields within the EMRs where self-management goals can be easily identified and progress on such can be reportable.										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 4 Train providers and staff on entering self-management goals data entering and monitoring.										
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.										
Task 1 Engage PCPs and train on and implement cardiovascular (CV) evidence based protocols ensuring attention to identification of behavioral health status and referral criteria.										
Task 2 Create protocol and processes for realization of "warm handoffs" when patients identified as needing behavioral health services. Utilize physician engagement team to implement and train staff at PCP office on "warm handoffs" of patients needing behavioral health services.										
Task 3 Provide PCPs with care teams' information and referral processes for providing referrals to and receiving information from CBOs, Behavioral and Mental health partners.										
Task 4 Establish central back office inclusive of care coordinators, care managers, community health workers and outreach staff with interfaces and two way connections that allow for upload of referrals as they are created by partners and as they are processed.										
Task 5 Establish and implement processes by which care coordinators receive and follow referrals as they are uploaded into Care management system electronically.										
Task 6 Establish and implement process and procedures by which care coordinators intervene in assisting patients in coordinating needed services from the full range of ACP partner providers and										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
community based organizations, local government and specialty agencies.										
Task 7 Establish process by which care coordinator central or at the practice site ensures receipt of services by patient and marks to send back to referring provider the result and outcome of services received by patient using.										
Task 8 Develop and implement procedures for warm handoffs as in previous tasks.										
Task 9 Establish periodicity of staff retraining to ensure comprehension and adherence to processes. Retraining to be minimally yearly but optimally twice yearly.										
Task 10 Perform analysis of CNA to determine community resources available.										
Task 11 Perform network analysis to determine size and scope of necessary resources										
Task 12 Draft CBO agreements and present to Board for approval. The CBO agreements will include services to be provided, timeliness of provision of services, ability and commitment to timely information exchange.										
Task 13 Utilize Community Engagement teams to Distribute RFP to CBOs to evaluate services, timeliness of services and CBO's capacity.										
Task 14 Utilize Community Engagement team to establish rapport, present formal agreements and obtain signed formal agreements.										
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.										
Task PPS has developed and implemented protocols for home blood pressure monitoring.										
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.										
Task PPS provides periodic training to staff on warm referral and										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
follow-up process.										
Task 1 Develop training manual for patients on how to measure BP. The manual includes proper technique and equipment use. The manual also contains guidance on values and goals with instruction on alert values and how to document the values.										
Task 2 Distribute BP manual to all practices for implementation and release to patients.										
Task 3 Engage physicians and their staff in implementation of manual and training the patient. The physician engagement team shall provide in-house training to physicians and all practice staff on how to use the training manual and how to train the patient on proper BP measuring.										
Task 4 Processes are put in place at PCP offices for staff to accept and evaluate patient's BP logs which the patient shall bring to every visit.										
Task 5 Staff is trained as per BP manual on evaluating equipment. BP levels measured at PCP office with patient equipment may be compared to readings at PCP office using office equipment.										
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task 1 Establish process for monthly data pulls from EMR registries for all patients with Hypertensive Cardiovascular disease by ICD code										
Task 2 Create filters for cross reference of reports pulled from EMR registries with parameters for all patients with hypertensive CV disease by ICD code/ date of last encounter/ and date of next visit. Identify all patients without a follow up appointment or who skipped a scheduled encounter.										
Task 3 Establish process for outreach to target patients and schedule a prompt appointment. PCPs allow for timely scheduling of the appointments.										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 4 Establish process for staff to communicate to CHWs patient lists/rosters who miss more than one appointment or are not reachable. CHW will provide services within the community and work to find the patient and connect the patient back to the PCP.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task 1 Establish procedures in accordance with evidence based protocols for referrals of tobacco users to NYS Smoker's Quitline.										
Task 2 Implement process for care coordinators and CHWs to receive and access referrals and follow up to ensure compliance and assist in care plan.										
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task 1 Perform CNA analysis to determine "hot spots". Determine neighborhoods with highest risk.										
Task 2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.										
Task 3 Utilize EMR technology to gather pertinent information. Activate features within EMR to capture REAL information and make this										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
capture mandatory within EMR to ensure compliance.										
Task 4 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.										
Task 5 As in previous tasks, Utilize community health workers to identify and establish agreements with CBOs that will then serve for implementation of Stanford model.										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	549	549	549	549	549	549	549	549	549	549
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	1,428	1,428	1,428	1,428	1,428	1,428	1,428	1,428	1,428	1,428
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	130	130	130	130	130	130	130	130	130	130
Task 1 With physician leads, Create ACP Million Hearts Campaign implementation and training materials.										
Task 2 Distribute Million Hearts Campaign implementation materials to all PCPs at physician engagement meetings, in person by Physician engagement team member, electronically.										
Task 3 Physician engagement team to provide PCPs training on million hearts campaign implementation to include BP checks without appointments, without copays, staff training and re-training and identifying a designated BP check area.										
Task 4 Working with community enterprises, organizations, MCOs and Physicians; ACP's Community Engagement team will negotiate and create patient compliance incentives to assist in motivating patients to adhere to treatment plans										
Task 5 Develop processes in accordance with million hearts campaign including patient self-management educational materials to be distributed to target patients and training provided at point of care										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
in provider office.										
Task 6 Develop patient training and educational materials for patient disease self-management techniques including how to monitor and record blood pressure levels at home.										
Task 7 Develop Lifestyle modification teaching and training materials including nutritional counseling.										
Task 8 In accordance with Million Hearts Campaign, Develop staff retraining tools and manuals and use provider engagement team to provide individual practice's staff members retraining on how to monitor blood pressures to ensure that patients can walk in to the practice and have their BP checked by any staff member at any time. The process will ensure that each staff member knows the correct technique and value assessment at the time that the patient comes in and is trained on the process to bring out of range values to the immediate attention of the provider.										
Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task 1 Leverage existing relationships with MCOs to negotiate extended coverage for target and affected population. The negotiating to include coverage for items such as BP machines for every patient with Hypertension, Nutritional counseling, smoking cessation medications and counseling as well as others.										
Task 2 Utilize existing relationships to negotiate and form agreements with MCOs by which copays are waived for BP check exams.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	549	549	549	549	549	549	549	549	549	549
Task 1 Leverage relationships within physician groups, IPAs, etc to engage physicians in ACP values.										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 2 Working with the finance department, formulate incentives for PCP participation.										
Task 3 Through physician engagement meetings, physician engagement teams, physician champions and other relationships; foster tight relationships with physicians and obtain agreements of participation with at least 80% of PCPs in ACP's network.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Facilitate referrals to NYS Smoker's Quitline.	jd593813	Other	25_PMDL4203_1_3_20160203173559_16.1_Cardiovascular_Protocol.pdf	Cardiovascular protocol addressing Smoker's Quitline and care coordination.	02/03/2016 05:35 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	1.2-1.4 Protocols established and disseminated
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.	2.4 Pls refer to the IT Roadmap uploaded under IT workstream for interim process.
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.	3.1 ACP Providers have been surveyed and categorized as PCMH-Certified EMR's, PCMH non-certified EMR's, and paper providers. Each level will indicate a level of readiness for PCMH transformation. 3.2 ACP has developed different strategies for implementing providers in each PCMH category as explained above. Those plans will establish the different timelines needed for the different needs each provider will have for PCMH transformation. 3.3 ACP has established communications to ACP safety net providers that establish key PCMH designated personnel, ACP/NCQA resources/PCMH Vendors, etc.
Use EHRs or other technical platforms to track all patients engaged in this project.	4.2 How To's created and disseminated to trained providers and staff
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	5.3 Protocols disseminated.
Adopt and follow standardized treatment protocols for hypertension	6.3 Provider engagement teams developed to work with providers.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
and elevated cholesterol.	
Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	7.2 Training materials created 7.6 Care teams established.
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	8.1 Participating provider agreements in place request compliance with all DSRIP projects, including blood pressure checks without fees.
Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	
Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	
Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	11.1 Protocols established including recommendations by JNC for daily regimens. 11.2 Physicians trained on protocol recommendations.
Document patient driven self-management goals in the medical record and review with patients at each visit.	12.1-12.2 Self management goals part of training for this project, including tracking of progress. 12.4 Self management goals entered into EHR, as part of training.
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	13.1-13.4 PCPs training on evidence based protocols, including warm handoffs for patients with BH issues. Patients with BH issues are referred to appropriate BH/MH providers, as well as CBOs. Back office function tracks process. 13.10-13.11 CNA performed and network resources identified. 13.12 CBO arrangements in place.
Develop and implement protocols for home blood pressure monitoring with follow up support.	14.3,14.5 Physician staff training by ACP to train patients with self monitoring blood pressure, including periodic testing of equipment by comparing readings.
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	15.1-15.2 Process for monthly data pulls established (interim solution in place), including exclusion lists for patients with missed appointments. 15.3 Process to target patients established.
Facilitate referrals to NYS Smoker's Quitline.	
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	17.1 CNA analysis complete. 17.4 Care teams established, including partner health homes.
Adopt strategies from the Million Hearts Campaign.	
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Engage a majority (at least 80%) of primary care providers in this project.	20.1 ACP leverages IPA and physician group relationships to achieve DSRIP goals.

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #1	Pass & Ongoing	
Milestone #2	Pass & Ongoing	
Milestone #3	Pass & Ongoing	
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Complete	
Milestone #17	Pass & Ongoing	
Milestone #18	Pass & Ongoing	
Milestone #19	Pass & Ongoing	
Milestone #20	Pass & Ongoing	

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

New York State Department Of Health
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DSRIP Implementation Plan Project

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

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

Instructions :

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

Project 3.c.i – Evidence-based strategies for disease management in high risk/affected populations (adults only)

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

Instructions :

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

ACP sees the following two major risks:
1. Based on customs and culture. The ACP PPS providers serve ethnic populations that are accustomed to high carbohydrate diets, and have low education and health literacy rates. Changing eating patterns that are passed from generation to generation will represent a great challenge for the PPS. To meet this challenge the PPS plans to leverage its cultural diversity and the integration of its culturally aligned providers to reach not only the patient in a language and tone that they can understand and accept, but also to reach the families and caregivers of these patients who are many times responsible for providing for the needs of the patient. The PPS will also provide education at the Primary Care level with regard to disease, disease prevention and disease management, directly one on one, and through educational materials/handouts and via the website and population wide campaigns.

2. Changing the mechanics of a primary care office which is already stressed and overworked and will now have to incorporate more teaching time. The PPS plans to meet this challenge by providing strong support and training to all staff so that there is not just one or two people available, but rather any available staff member may provide the needed service. ACP will create the educational materials and have a communications and outreach team put together patient incentives. The PPS will also negotiate with MCOs to cover the full cost of blood pressure for all patients with hypertension in any of its forms.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	223,035

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
78,062	111,517	100.00%	0	50.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
jd593813	Rosters	25_PMDL4415_1_3_20160203175350_DM_Patient_Engagement.xlsx	Patient Engagement File	02/03/2016 05:54 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 In conjunction with physician leads who are endocrinologists and internists Develop evidence based protocols in accordance with ADA guidelines for evaluation and treatment of patients with Diabetes.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Disseminate and Implement protocols and procedures to physicians via physician engagement meetings, on site trainings and electronic format.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 3 Based on protocol guidelines for evaluation, create a reporting system for using EMR registries to identify target patients, ie. HgbA1C, Kidney Function, Cholesterol levels.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4 Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and educational services as needed	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5 Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
one on one by the physician engagement team members. Protocols are also be made distributed electronically to every provider.									
Task 6 Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 7 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 8 Employ physician engagement teams to hand deliver protocols and process and procedure manuals to providers and office staff and provide training on implementation processes.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Leverage physician groups such as IPAs, physician champions, Hospital partners, etc. in to engage PCPs in the implementation of the project.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Physician engagement team members to visit all PCPs provide assistance and training. Through onsite visits and their one on one interactions foster relationships, provide assistance and training and obtain further commitments from PCPs toward the achievement of the 80% participation.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Care coordination processes are established and implemented.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, diabetic educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
the data to target high risk populations, develop improvement plans, and address top health disparities.									
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1 Perform CNA analysis to determine "hot spots". Determine neighborhoods with highest risk.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3 Utilize EMR technology to gather pertinent information. Activate features within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Utilize REAL data provided in EMR to arrange Stanford Model activities in location, language and culture of the population to be addressed.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1 Leverage existing relationships between physician groups and	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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DSRIP Implementation Plan Project

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
MCOs to bring to the table MCO executives for contract negotiations with ACP.									
Task 2 Produce reports with comparison analytic data on healthcare costs for complicated Diabetes patients versus ROI when preventative care is provided from onset of diabetes and throughout.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3 Leverage analytic data to negotiate on behalf of ACP patients to obtain extension of coverage for evidence based prescribed preventive services. Service to include eye and vision screening, smoking cessation therapy, Cardiovascular disease evaluation, periodic preventive Renal function testing, and several others.	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 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.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Create "how to" training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
3 Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as HgbA1C levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.									
Task 4 ACP will leverage existing EMR systems and create recall criteria to ensure that all patients are tracked and receive services timely. The criteria will include laboratory data such as last HgbA1c, visit data such as last visit, last comprehensive preventive physical, last eye exam and other criteria. Periodicity will vary depending on service.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #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.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
mimic what we have in place for project 2ai.									
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.										
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease management are developed and training of staff is completed.										
Task 1 In conjunction with physician leads who are endocrinologists and internists Develop evidence based protocols in accordance with ADA guidelines for evaluation and treatment of patients with Diabetes.										
Task 2 Disseminate and Implement protocols and procedures to physicians via physician engagement meetings, on site trainings and electronic format.										
Task 3 Based on protocol guidelines for evaluation, create a reporting system for using EMR registries to identify target patients, ie. HgbA1C, Kidney Function, Cholesterol levels.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 4 Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and educational services as needed										
Task 5 Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members. Protocols are also be made distributed electronically to every provider.										
Task 6 Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.										
Task 7 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.										
Task 8 Employ physician engagement teams to hand deliver protocols and process and procedure manuals to providers and office staff and provide training on implementation processes.										
Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	55	165	220	275	329	384	549	549	549
Task 1 Leverage physician groups such as IPAs, physician champions, Hospital partners, etc. in to engage PCPs in the implementation of the project.										
Task 2 Physician engagement team members to visit all PCPs provide assistance and training. Through onsite visits and their one on one interactions foster relationships, provide assistance and training and obtain further commitments from PCPs toward the achievement of the 80% participation.										
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are established and implemented.										
Task 1 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.										
Task 2 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.										
Task 3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, diabetic educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.										
Task 4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.										
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task 1 Perform CNA analysis to determine "hot spots". Determine neighborhoods with highest risk.										
Task 2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.										
Task 3 Utilize EMR technology to gather pertinent information. Activate features within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.										
Task 4 Utilize REAL data provided in EMR to arrange Stanford Model activities in location, language and culture of the population to be addressed.										
Task 5 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.										
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task 1 Leverage existing relationships between physician groups and MCOs to bring to the table MCO executives for contract negotiations with ACP.										
Task 2 Produce reports with comparison analytic data on healthcare costs for complicated Diabetes patients versus ROI when preventative care is provided from onset of diabetes and throughout.										
Task 3 Leverage analytic data to negotiate on behalf of ACP patients to obtain extension of coverage for evidence based prescribed preventive services. Service to include eye and vision screening,										

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
smoking cessation therapy, Cardiovascular disease evaluation, periodic preventive Renal function testing, and several others.										
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 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.										
Task 1 Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.										
Task 2 Create "how to" training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.										
Task 3 Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as HgbA1C levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.										
Task 4 ACP will leverage existing EMR systems and create recall criteria to ensure that all patients are tracked and receive services timely. The criteria will include laboratory data such as last HgbA1c, visit data such as last visit, last comprehensive preventive physical, last eye exam and other criteria. Periodicity will vary depending on service.										
Milestone #7 Meet Meaningful Use and PCMH Level 3 standards and/or										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
APCM by the end of Demonstration Year 3 for EHR systems used by participating safety net providers.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	55	110	193
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	51	101	176
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	50	100	174
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	0	0	0	0	0	0	0	10	20	34
Task Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).										
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.										
Task 4 Start to implement plan to ensure safety net providers achieve MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.										
Task Evidence-based strategies for the management and control of diabetes in the PPS designated area are developed and implemented for all participating providers. Protocols for disease										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
management are developed and training of staff is completed.										
Task 1 In conjunction with physician leads who are endocrinologists and internists Develop evidence based protocols in accordance with ADA guidelines for evaluation and treatment of patients with Diabetes.										
Task 2 Disseminate and Implement protocols and procedures to physicians via physician engagement meetings, on site trainings and electronic format.										
Task 3 Based on protocol guidelines for evaluation, create a reporting system for using EMR registries to identify target patients, ie. HgbA1C, Kidney Function, Cholesterol levels.										
Task 4 Develop processes and procedures to comply with the protocols for identifying needed referrals, specialty needs and promoting referral for behavioral health and social and educational services as needed										
Task 5 Disseminate evidence based protocols for implementation by ACP partners via physician engagement meetings as well as one on one by the physician engagement team members. Protocols are also be made distributed electronically to every provider.										
Task 6 Develop a process and procedure manual for the implementation of the protocols in a consistent way throughout the PPS, including the incorporation of processes within the EMR.										
Task 7 User friendly materials are created on how to implement the protocol and how to enter searchable information into EMR for ease of reporting and performance and engagement monitoring.										
Task 8 Employ physician engagement teams to hand deliver protocols and process and procedure manuals to providers and office staff and provide training on implementation processes.										
Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.										
Task PPS has engaged at least 80% of their PCPs in this activity.	549	549	549	549	549	549	549	549	549	549

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 1 Leverage physician groups such as IPAs, physician champions, Hospital partners, etc. in to engage PCPs in the implementation of the project.										
Task 2 Physician engagement team members to visit all PCPs provide assistance and training. Through onsite visits and their one on one interactions foster relationships, provide assistance and training and obtain further commitments from PCPs toward the achievement of the 80% participation.										
Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.										
Task Clinically Interoperable System is in place for all participating providers.										
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.										
Task Care coordination processes are established and implemented.										
Task 1 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.										
Task 2 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.										
Task 3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, diabetic educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.										
Task 4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.										
Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.										
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.										
Task If applicable, PPS has established linkages to health homes for targeted patient populations.										
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task 1 Perform CNA analysis to determine "hot spots". Determine neighborhoods with highest risk.										
Task 2 Utilize Community engagement teams to prepare Stanford Model meetings and educational materials in the hot spot neighborhoods. The implementation of the Stanford model shall be conducted in the language and culture of the target audience taking into account any and all cultural sensitivities.										
Task 3 Utilize EMR technology to gather pertinent information. Activate features within EMR to capture REAL information and make this capture mandatory within EMR to ensure compliance.										
Task 4 Utilize REAL data provided in EMR to arrange Stanford Model activities in location, language and culture of the population to be addressed.										
Task 5 Implement process to ensure that partner health homes and those that are members of the Care Teams are linked with patients meeting criteria and eligibility as per ACA.										
Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.										
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.										
Task 1 Leverage existing relationships between physician groups and MCOs to bring to the table MCO executives for contract negotiations with ACP.										
Task 2 Produce reports with comparison analytic data on healthcare costs for complicated Diabetes patients versus ROI when preventative care is provided from onset of diabetes and throughout.										
Task 3 Leverage analytic data to negotiate on behalf of ACP patients to obtain extension of coverage for evidence based prescribed preventive services. Service to include eye and vision screening, smoking cessation therapy, Cardiovascular disease evaluation, periodic preventive Renal function testing, and several others.										
Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 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.										
Task 1 Create and instruct practices on input of information in structured format into EMR to be able to mine data for engagement and performance. Metric data will include use of home grown and CPT codes to monitor and extrapolate several levels of care provided from lifestyle modification training to patients, to use of nutritional counseling CPT codes, EMR MU data dashboards that provide analysis of tobacco use assessment tools and counseling, among others.										
Task 2 Create "how to" training tools to be provided at the practice level for simplified physician and staff training in order to increase compliance and correct collection of data for monitoring engagement and performance.										
Task 3 Develop EMR reports using EMR reporting tools for practice management, MU dashboards, registries to pull data relevant to project implementation, find target patients, monitor patient										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
engagement, and attainment of goals. These data pulls will be analyzed based on data collected such as HgbA1C levels, cholesterol levels, Medications and medication dosages, lifestyle modification techniques in place, counseling, number of encounters, referrals and completion of these, as well as other data as determined necessary by the PPS.										
Task 4 ACP will leverage existing EMR systems and create recall criteria to ensure that all patients are tracked and receive services timely. The criteria will include laboratory data such as last HgbA1c, visit data such as last visit, last comprehensive preventive physical, last eye exam and other criteria. Periodicity will vary depending on service.										
Milestone #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.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	385	549	549	549	549	549	549	549	549	549
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	351	501	501	501	501	501	501	501	501	501
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	348	496	496	496	496	496	496	496	496	496
Task EHR meets connectivity to RHIO/SHIN-NY requirements.	68	96	96	96	96	96	96	96	96	96
Task Survey and group all participating safety net providers into level of readiness. The strategy around this milestone will directly mimic what we have in place for project 2ai.										
Task 2 Develop plan, timelines, and assign resources for each level of readiness. This includes PPS-defined readiness levels with strategies that will vary based the different levels (ie those who are technologically integrated will have a different approach than providers who are still utilizing paper medical records).										
Task 3 Establish communications / marketing plan and outreach to all ACP safety net providers that also identifies support resources.										
Task 4 Start to implement plan to ensure safety net providers achieve										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
MU/PCMH Level 3 by end of DY3. Implementation plan includes support from resources including PCMH CCEs. Support may include internal or external resources.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	1.8 Protocols disseminated and physicians have been trained
Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	
Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	Care coordination teams are in place (ie Care Teams) and processes have been established.
Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	4.1 CNA hotspot analysis complete.
Ensure coordination with the Medicaid Managed Care organizations serving the target population.	5.1 MCO leads convened and presented with project and data asks as it relates to DSRIP.
Use EHRs or other technical platforms to track all patients engaged in this project.	
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.	7.1 ACP Providers have been surveyed and categorized as PCMH-Certified EMR's, PCMH non-certified EMR's, and paper providers. Each level will indicate a level of readiness for PCMH transformation. 7.2 ACP has developed different strategies for implementing providers in each PCMH category as explained above. Those plans will establish the different timelines needed for the different needs each provider will have for PCMH transformation. 7.3 ACP has established communications to ACP safety net providers that establish key PCMH designated personnel, ACP/NCQA/PCMH Vendors resources, etc.

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 3.d.iii – Implementation of evidence-based medicine guidelines for asthma management

IPQR Module 3.d.iii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

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

Major risks to implementation revolve around ascertaining environmental risk factor and trigger information and taking action to reduce or eliminate these. Many of the patients served by ACP are of Low Socio-economic status and have low health literacy rates. They may be accustomed to living conditions and environmental conditions that they believe to be normal or non-changeable and thus fail to report these. Asthma is a disease with high sensitivity to environmental factors. ACP plans to mitigate this risk by fostering tight bonds between the patient and the PCP so as to create and maintain open honest lines of communication. ACP will also provide the patients with health education both at the primary care setting as well as via the inclusion of CBOs to work with the patients and make them aware of disease management and prevention tools. ACP will also work closely with state and local departments to provide assistance with environmental hazards. ACP will also work closely with the Asthma coalition on patient education and attainment of services.

2. Another risk factor also related to health literacy but also involving other persons in contact with the patient revolves around schools, caregivers, and family members not knowing the appropriate action to take to help the asthmatic patient. ACP is implementing evidence based protocols and school/work and home/family Asthma action plans to better allow for the asthmatic patients to receive proper care in their current setting.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	169,199

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
32,513	63,269	74.79%	21,330	37.39%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (84,599)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
jd593813	Rosters	25_PMDL4815_1_3_20160203181310_AST_Patient_Engagement.xlsx	Patient Engagement File	02/03/2016 06:13 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement 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.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Working with physician leads who are internists, pediatricians, pulmonologist and in accordance with NIH guidelines, develop evidence based protocols for evaluation and management of Asthma in adults and children.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Develop processes for referrals as prescribed by evidence based protocol for referring patients to specialists and specialty services including community based organizations and	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
programs. Process shall include care coordination by ACP's central back office care coordinator team.									
Task 4 Obtain signed service agreements between ACP and participating providers.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5 Establish relationships and agreements with schools and other community based organizations and programs that can be a part of the ACP Care Teams, provide necessary services to patients and assist/support in implementation of evidence based asthma management action plans.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 7 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 8 Utilize EMR interfaces, data feeds, interconnectivity capabilities to connect all providers within the PPS to be able to have more immediate information exchange between partners.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 9 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Agreements with asthma specialists and asthma educators are	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
established.									
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1 Develop ACP participating provider service agreements. The agreement shall include provider commitment to adhering to ACP developed evidence based protocols and processes and obtain Board approval.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Distribute agreement and obtain signed commitment from all providers of all provoder types to adhere to ACP evidence based protocols and processes. Obtaining signed agreements shall be a concerted effort on behalf of ACP and will leverage physician groups such as IPAs, as well as Hospital partner's relationships with providers in their area and physician engagement team.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, asthma educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.									
Task 5 Develop telemedicine capabilities within the ACP central back office Care Coordination/ Care management.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6 Review "hot spotting" results and CNA resource analysis, ACP network analysis and REAL data to target patients meeting those criteria for telemedicine and in the language and culturally sensitive manner as appropriate	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7 Perform analysis of accessibility of broadband services in areas where CNA analysis reveals the need to implement telemedicine to augment services and bridge gaps.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8 PPS to leverage Community Engagement team to negotiate with broadband service providers in areas where this service is necessary for population wide reach of care for reduced rates and incentives.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.	Project	N/A	Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Participating providers receive training in evidence-based asthma management.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1 Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Develop user friendly versions of the protocol and processes.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 3 Develop Asthma action plans for home work and school that can be incorporated into EMR for ease of access, efficient	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
implementation for patient and tracking within the EMR system for tracking engagement and performance within the EMR.									
Task 4 Utilize physician engagement team to distribute process and procedure materials and provide on-site training on implementation of protocol and protocol processes at the providers office to providers and staff.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.	Project	N/A	In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS has 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.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1 ACP will maintain close communications and information exchange with MCOs and Health Homes through direct feeds, referrals, data analysis and most over through these agency participation in the ACP Care Teams and PAC to ensure smooth coordination of care and creation of processes as necessary.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2 Develop processes for identification of HH eligible patients, referral of these patients to HH and coordinating transition and care through HH.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Establish ACP back office processes and procedures for coordinating care with MCOs obtaining necessary authorizations and fulfilling patient needs for services.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 Leverage existing relationships with MCOs to negotiate extended coverage for target and affected population. The negotiating to include coverage for items such as nebulizers for every patient with asthma, smoking cessation medications and counseling as well as others.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1 Incorporate Asthma action plans into the provider's EMR for ease of access, avoidance of duplication and tracking control.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2 Work with EMR vendors and IT departments to structure fields in which data is entered when patient is engaged and then extrapolated for tracking	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3 Utilize EMR's patient registries, MU dashboards, PCMH capabilities to obtain reports on patients engaged and those needing to be reached. Process will include filters by ICD and appointment date as well as other data useful in ascertaining patient compliance and health risk stratification and to identify target patients..	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4 Create processes and parameters within the EMRs that will also serve in the purpose of performance and compliance monitoring through flow sheets, interfaces with diagnostic entities to track disease progression efficacy of treatment, medication and dosing tracking, episode frequency and service utilization.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5 Create interconnectivity between provider EMRs the ACP platform, ACP will track Medication management, counseling, referrals and their completion.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 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.										
Task PPS has agreements from participating providers and community										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
programs to support a evidence-based asthma management guidelines.										
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	0	180	586	902	902	902	902	902	902	902
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	0	286	928	1,428	1,428	1,428	1,428	1,428	1,428	1,428
Task 1 Working with physician leads who are internists, pediatricians, pulmonologist and in accordance with NIH guidelines, develop evidence based protocols for evaluation and management of Asthma in adults and children.										
Task 2 Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.										
Task 3 Develop processes for referrals as prescribed by evidence based protocol for referring patients to specialists and specialty services including community based organizations and programs. Process shall include care coordination by ACP's central back office care coordinator team.										
Task 4 Obtain signed service agreements between ACP and participating providers.										
Task 5 Establish relationships and agreements with schools and other community based organizations and programs that can be a part of the ACP Care Teams, provide necessary services to patients and assist/support in implementation of evidence based asthma management action plans.										
Task 6 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.										
Task 7 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.										
Task 8 Utilize EMR interfaces, data feeds, interconnectivity capabilities										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
to connect all providers within the PPS to be able to have more immediate information exchange between partners.										
Task 9 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.										
Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.										
Task Agreements with asthma specialists and asthma educators are established.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	38	150	262	524	748	748	748
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	25	100	174	348	496	496	496
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability										
Task 1 Develop ACP participating provider service agreements. The agreement shall include provider commitment to adhering to ACP developed evidence based protocols and processes and obtain Board approval.										
Task 2 Distribute agreement and obtain signed commitment from all providers of all provoder types to adhere to ACP evidence based protocols and processes. Obtaining signed agreements shall be a concerted effort on behalf of ACP and will leverage physician groups such as IPAs, as well as Hospital partner's relationships										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
with providers in their area and physician engagement team.										
Task 3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, asthma educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.										
Task 4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.										
Task 5 Develop telemedicine capabilities within the ACP central back office Care Coordination/ Care management.										
Task 6 Review "hot spotting" results and CNA resource analysis, ACP network analysis and REAL data to target patients meeting those criteria for telemedicine and in the language and culturally sensitive manner as appropriate										
Task 7 Perform analysis of accessibility of broadband services in areas where CNA analysis reveals the need to implement telemedicine to augment services and bridge gaps.										
Task 8 PPS to leverage Community Engagement team to negotiate with broadband service providers in areas where this service is necessary for population wide reach of care for reduced rates and incentives.										
Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.										
Task Participating providers receive training in evidence-based asthma management.										
Task 1 Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.										
Task 2 Develop user friendly versions of the protocol and processes.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 3 Develop Asthma action plans for home work and school that can be incorporated into EMR for ease of access, efficient implementation for patient and tracking within the EMR system for tracking engagement and performance within the EMR.										
Task 4 Utilize physician engagement team to distribute process and procedure materials and provide on-site training on implementation of protocol and protocol processes at the providers office to providers and staff.										
Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.										
Task 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.										
Task 1 ACP will maintain close communications and information exchange with MCOs and Health Homes through direct feeds, referrals, data analysis and most over through these agency participation in the ACP Care Teams and PAC to ensure smooth coordination of care and creation of processes as necessary.										
Task 2 Develop processes for identification of HH eligible patients, referral of these patients to HH and coordinating transition and care through HH.										
Task 3 Establish ACP back office processes and procedures for coordinating care with MCOs obtaining necessary authorizations and fulfilling patient needs for services.										
Task 4 Leverage existing relationships with MCOs to negotiate extended coverage for target and affected population. The negotiating to include coverage for items such as nebulizers for every patient with asthma, smoking cessation medications and counseling as well as others.										
Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

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

DSRIP Implementation Plan Project

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

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 1 Incorporate Asthma action plans into the provider's EMR for ease of access, avoidance of duplication and tracking control.										
Task 2 Work with EMR vendors and IT departments to structure fields in which data is entered when patient is engaged and then extrapolated for tracking										
Task 3 Utilize EMR's patient registries, MU dashboards, PCMH capabilities to obtain reports on patients engaged and those needing to be reached. Process will include filters by ICD and appointment date as well as other data useful in ascertaining patient compliance and health risk stratification and to identify target patients..										
Task 4 Create processes and parameters within the EMRs that will also serve in the purpose of performance and compliance monitoring through flow sheets, interfaces with diagnostic entities to track disease progression efficacy of treatment, medication and dosing tracking, episode frequency and service utilization.										
Task 5 Create interconnectivity between provider EMRs the ACP platform, ACP will track Medication management, counseling, referrals and their completion.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.										
Task PPS has agreements from participating providers and community programs to support a evidence-based asthma management guidelines.										
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	902	902	902	902	902	902	902	902	902	902
Task All participating practices have a Clinical Interoperability System in place for all participating providers.	1,428	1,428	1,428	1,428	1,428	1,428	1,428	1,428	1,428	1,428

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 1 Working with physician leads who are internists, pediatricians, pulmonologist and in accordance with NIH guidelines, develop evidence based protocols for evaluation and management of Asthma in adults and children.										
Task 2 Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.										
Task 3 Develop processes for referrals as prescribed by evidence based protocol for referring patients to specialists and specialty services including community based organizations and programs. Process shall include care coordination by ACP's central back office care coordinator team.										
Task 4 Obtain signed service agreements between ACP and participating providers.										
Task 5 Establish relationships and agreements with schools and other community based organizations and programs that can be a part of the ACP Care Teams, provide necessary services to patients and assist/support in implementation of evidence based asthma management action plans.										
Task 6 Create IDS with two way information exchange between all ACP partners including physicians, hospitals, diagnostic entities, CBOs, homecare agencies, and others.										
Task 7 Develop a central care coordination/care management system platform that will interface with ACP providers and be able to receive referral data for timely care coordination and processing of services and will allow for referral data to be updated back to referring provider noting completion of task.										
Task 8 Utilize EMR interfaces, data feeds, interconnectivity capabilities to connect all providers within the PPS to be able to have more immediate information exchange between partners.										
Task 9 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
services including social services, transportation, etc.										
Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.										
Task Agreements with asthma specialists and asthma educators are established.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	748	748	748	748	748	748	748	748	748	748
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	496	496	496	496	496	496	496	496	496	496
Task Telemedicine service implemented, based on evaluation of impact to underserved areas including, but not limited to: - analysis of the availability of broadband access in the geographic area being served - gaps in services - geographic areas where PPS lacks resources and telemedicine will be used to increase the reach of these patients - why telemedicine is the best alternative to provide these services - challenges expected and plan to pro-actively resolve - plan for long term sustainability										
Task 1 Develop ACP participating provider service agreements. The agreement shall include provider commitment to adhering to ACP developed evidence based protocols and processes and obtain Board approval.										
Task 2 Distribute agreement and obtain signed commitment from all providers of all provoder types to adhere to ACP evidence based protocols and processes. Obtaining signed agreements shall be a concerted effort on behalf of ACP and will leverage physician groups such as IPAs, as well as Hospital partner's relationships with providers in their area and physician engagement team.										
Task 3 Develop ACP central back office consisting of Care coordinators, Care managers, Community Health Workers, asthma educators, pharmacists and others to provide additional and enhanced care including patient education on disease self-management.										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 4 Develop processes for back office/care coordination and care management teams to provide intervention as needed based on information received at ACP's central back office. The care coordination team will be responsible for monitoring and following up on referrals and assisting the patient in receiving needed services including social services, transportation, etc.										
Task 5 Develop telemedicine capabilities within the ACP central back office Care Coordination/ Care management.										
Task 6 Review "hot spotting" results and CNA resource analysis, ACP network analysis and REAL data to target patients meeting those criteria for telemedicine and in the language and culturally sensitive manner as appropriate										
Task 7 Perform analysis of accessibility of broadband services in areas where CNA analysis reveals the need to implement telemedicine to augment services and bridge gaps.										
Task 8 PPS to leverage Community Engagement team to negotiate with broadband service providers in areas where this service is necessary for population wide reach of care for reduced rates and incentives.										
Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.										
Task Participating providers receive training in evidence-based asthma management.										
Task 1 Implement Evidence based protocol throughout the PPS providers via provider engagement meetings, provider engagement team member outreach to providers, PMO distribution of electronic versions of protocols.										
Task 2 Develop user friendly versions of the protocol and processes.										
Task 3 Develop Asthma action plans for home work and school that can be incorporated into EMR for ease of access, efficient implementation for patient and tracking within the EMR system for tracking engagement and performance within the EMR.										
Task 4 Utilize physician engagement team to distribute process and procedure materials and provide on-site training on										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
implementation of protocol and protocol processes at the providers office to providers and staff.										
Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.										
Task 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.										
Task 1 ACP will maintain close communications and information exchange with MCOs and Health Homes through direct feeds, referrals, data analysis and most over through these agency participation in the ACP Care Teams and PAC to ensure smooth coordination of care and creation of processes as necessary.										
Task 2 Develop processes for identification of HH eligible patients, referral of these patients to HH and coordinating transition and care through HH.										
Task 3 Establish ACP back office processes and procedures for coordinating care with MCOs obtaining necessary authorizations and fulfilling patient needs for services.										
Task 4 Leverage existing relationships with MCOs to negotiate extended coverage for target and affected population. The negotiating to include coverage for items such as nebulizers for every patient with asthma, smoking cessation medications and counseling as well as others.										
Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1 Incorporate Asthma action plans into the provider's EMR for ease of access, avoidance of duplication and tracking control.										
Task 2 Work with EMR vendors and IT departments to structure fields in which data is entered when patient is engaged and then extrapolated for tracking										
Task 3 Utilize EMR's patient registries, MU dashboards, PCMH										

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

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
capabilities to obtain reports on patients engaged and those needing to be reached. Process will include filters by ICD and appointment date as well as other data useful in ascertaining patient compliance and health risk stratification and to identify target patients..										
Task 4 Create processes and parameters within the EMRs that will also serve in the purpose of performance and compliance monitoring through flow sheets, interfaces with diagnostic entities to track disease progression efficacy of treatment, medication and dosing tracking, episode frequency and service utilization.										
Task 5 Create interconnectivity between provider EMRs the ACP platform, ACP will track Medication management, counseling, referrals and their completion.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Deliver educational activities addressing asthma management to participating primary care providers.	jd593813	Policies/Procedures	25_PMDL4803_1_3_20160316115039_Practitioner_Engagement_2_-_Physician_Engagement_Process.pdf	Remediation response to 3diii Milestone 3 - Physician Engagement process that addresses training.	03/16/2016 11:50 AM
	jd593813	Other	25_PMDL4803_1_3_20160316114810_3diii_3_-_Asthma_Educational_Materials.pdf	Remediation response to 3diii Milestone 3 - training materials attached.	03/16/2016 11:48 AM
	jd593813	Meeting Materials	25_PMDL4803_1_3_20160315232644_ACP_Physician_Engagement_2015_11_17.pptx	Remediation response to 3diii Milestone 3 - training materials attached. General meeting describes Asthma project and introduces protocol (previously attached).	03/15/2016 11:26 PM
	jd593813	Other	25_PMDL4803_1_3_20160203180821_3.1_Asthma_Protocol.pdf	Asthma Protocol	02/03/2016 06:08 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	1.3 Referral process developed.

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

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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 physicians developed.
Deliver educational activities addressing asthma management to participating primary care providers.	Appropriate training for this project have been provided to physicians and providers. 3.4 protocols disseminated.
Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected population.	
Use EHRs or other technical platforms to track all patients engaged in this project.	5.3 Physician EHR registries in use to pull reports for patients requiring engagement.

Milestone Review Status

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

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DSRIP Implementation Plan Project

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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DSRIP Implementation Plan Project

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

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

Instructions :

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

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

Project 4.b.i – Promote tobacco use cessation, especially among low SES populations and those with poor mental health.

IPQR Module 4.b.i.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

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

Success with tobacco cessation has not been great historically. ACP anticipates that achieving success in this project will be difficult. ACP recognizes that addictions many times have multifactorial causes including:

1. Culture. Smoking is perceived as "cool" in many cultures and considered acceptable as a recreational tool. Therefore, patients are resistant to quitting for fear of alienation from peers. ACP will overcome this challenge by speaking to patients in a language and culturally relevant manner that the patient can understand and relate to. This will be overcome since ACP has over 2000 physicians who themselves are of the same minority as the patient.

2. Patient Adherence. Patient's acceptance and adherence to treatment plans and follow through will be a challenge. ACP will face this challenge by providing "warm" handoffs of the patient to one of our partners or to an employed counselor. The PPS will address this with increased, culturally sensitive educational efforts, ongoing monitoring and consistent implementation of the tobacco use cessation protocol across providers.

3. Cost. Currently, cessation programs may be expensive and the patient will not follow through for lack of sufficient income. ACP plans to address this challenge by negotiating with relevant MCOs to provide coverage for services and supplies needed in the treatment of tobacco addiction.

4. Monitoring. Another key challenge will be monitoring the metrics with such a large network of providers who have a variety of EHRs or paper documentation processes. We will establish a data warehouse to collect, store, and analyze data across these provider sources, and are planning a concentrated effort to expand EHR use across all providers.

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

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Data Analysis	In Progress	Analyze CNA results to understand prevalence of tobacco use in specific areas.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1 Identification of Hotspots	Completed	1 Analyze CNA data to determine "hotspots" (areas of highest incidence of tobacco use)	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2 Complete Analysis	Completed	2 Complete analysis of CNA to identify resources within the "hot spot"	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Community Health Workers	In Progress	3 Hire and train community health workers of the language and culture of the hot spot population served to provide outreach and promotion to populations underserved by most mass outlets and provide various degrees of engagement (large events, small group, etc).	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone Develop and Implement Tobacco Use Cessation Protocol	In Progress	Develop tobacco use cessation protocol and deploy to providers within PPS.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Develop Evidence Based Protocols	Completed	1 Develop and implement evidence based protocols for assessing tobacco use and implementing tobacco use cessation therapies working in conjunction with physician leads and in accordance with NIH guidelines.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Disseminate Protocols with Providers	In Progress	2 Distribute protocols and procedures at physician engagement meetings, Care team meetings, electronically and utilizing provider engagement teams.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone Educational Campaign	In Progress	Develop and implement educational campaign and protocols for ACP providers	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Protocol Implementation	Completed	1 Utilize provider engagement team to provide on-site training and education at individual practices on implementing of protocols and procedures for assessing and treating tobacco use.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Promote Use of EHR	In Progress	2 Promote amongst ACP's partners a workflow that includes the use of tobacco use assessment tools specifically the 5 A's incorporating the assessment tool into the EMR	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3 Implement Treatment Plan	Completed	3 Providers implement treatment plans in accordance with evidence based protocols for tobacco use cessation intervention	09/30/2015	12/31/2015	09/30/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone Engage MCOs Regarding Benefit Package	In Progress	Initiate tobacco reimbursement and benefit negotiations with MCO.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1 Data Analysis	In Progress	1 Analyze tobacco use costs to healthcare, including costs associated with all secondary effects of tobacco, precipitation of disease, aggravation of disease.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2 Engage MCOs	In Progress	2 Leverage relationships and partnerships between MCOs and physicians and physician groups to bring to the table high level administrators to negotiate coverage of evidence based treatments at no cost to the patient.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3 Present Cost Analysis	In Progress	3 Present cost analysis and ROI for early intervention and cost of tobacco cessation treatment including treatment that is pharmaceutical and /or cessation counseling. Utilize analysis results to determine initiatives from incentives to outreach support.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4 Partnership Strategies	In Progress	4 Use community health workers and community resources, pharmaceutical companies, MCOs and others to negotiate patient incentives for adherence to tobacco cessation programs and treatment plans and for successful attainment of goals.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone CBO Support and Resources	In Progress	Seek out and establish a network of community-based support resources.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1 Identify Key Providers and Support Agencies	In Progress	1 Identify key contacts at and establish partnerships with local government and community based organizations that have established, proven track record in promoting tobacco use cessation. Such entities include NYQUITS, local community daycare and social centers, churches, schools. etc. to promote healthy lifestyle and tobacco free zones.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2 Educational Materials	In Progress	2 In conjunction with physician leads, tobacco cessation champions, clinical quality committees develop educational materials in several languages and culturally appropriate manner educating patients on tobacco use and its effects and detriment to health at primary and secondary exposure. Educational materials will be shared with key providers and other support agencies.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone Screening and Treatment Campaign	In Progress	Implement population wide screening and treatment of patients with Media campaign with key partners, providers and other support agencies.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1 Media Campaign	In Progress	1 With communications team develop "Talk to your doctor about Tobacco" media campaign highlighting tobacco use effects, through primary and secondary exposure, Quit techniques and resources	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2 Educational Materials	In Progress	2 In conjunction with tobacco cessation champion partners such as Jamaica Hospital; Develop educational materials on the effects and consequences of tobacco use.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3 Disseminate Educational Materials	In Progress	3 Disseminate educational materials via print , visual, audio and electronic media. Utilize community health workers and CBOs to disseminate materials within the communities.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4 Engage Media Outlets to Increase Effectiveness of Existing Campaigns	In Progress	4 Leverage established relationships with key providers and stakeholders. Partner with New York City organizations which are already providing tobacco use cessation through the media to increase outreach to communities that may not be attentive to them as of now.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5 Culturally Sensitive Educational Materials	In Progress	5 Ensure that all materials are made available and distributed in the communities in a language and culture that is appropriate and sensitive.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone Care Coordination Plans	In Progress	Develop Care Coordination Plans Using Evidence-Based Protocols As Part of the Integrated Delivery System	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1 Evidence Based Protocols and Assessments	In Progress	1 In conjunction with physician leads and in accordance with NCBI and CDC guidelines, Develop Evidence based tobacco cessation protocols which include assessments incorporated into EMR, treatment plans both pharmaceutical treatments as well as cessation counseling.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2 Disseminate Evidence Based Protocols	Completed	2 Disseminate and Implement evidence based protocols for tobacco use cessation. Physician engagement teams shall deliver and train practices on the use of the protocols and process and procedures contained within.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3 Care Coordination Processes	In Progress	3 As mandated within protocol, develop processes for care coordination processes for referral and follow up and follow through of services. Develop Back Office/Care Coordination, Care Management teams to receive and follow through in the integrated model of care with completion of referrals/services and link to community resources and social services to assist and provide care for patients as requested by providers.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task	In Progress	4 Structure Care teams to support tobacco use cessation	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
4 Care Team Support		intervention and provide Care Coordinators with appropriate information through ACP's IT platform to support the IDS						
Task 5 Determine Success Factors	In Progress	5 Measure effectiveness of care coordination and support. Success of programs will need to incorporate culture of population, ACP will establish processes and educational materials to ensure cultural definitions and images of tobacco use are addressed and corrected. ACP will use whenever possible warm handoffs to specialty services and programs, will prioritize needs and provide ongoing monitoring via the Care Coordination teams and Community Health Workers.	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6 Connect to HIE with Provider Network	In Progress	6 Connect via EMR, RHIO, SHINY, ACP IT Platform; all network providers to provide efficient information exchange and expedite services. IT platform will include secure login for information exchange between PPS and community partners without EMRs.	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone Success Factors	In Progress	Include Key Success Factors Within Plan Including Analytics to Determine Effectiveness of Programs	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1 Utilize EMR Data Capabilities Specific to Tobacco Use Cessation Initiative	In Progress	1 Leverage existing EMR meaningful use data mining capabilities to identify, gather information on and target all tobacco users to develop reporting metrics	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2 Establish Reporting Metrics	In Progress	2 Develop algorithm and trending for evaluating success rates based on initial and follow up assessment tool responses. These include number of packs per day, number of cigarettes a day, how long after waking up in the morning, etc. Trending will show increases and decreases that can be used to evaluate care plan effectiveness.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3 Comparative Analytics and Application	In Progress	3 Develop comparison data analytics between data mined from assessment tool responses/by zones (hot spots)/amount of created and disseminated educational resources/ACP partner to establish more population wide effectiveness of programs.	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone Partnerships with Other PPSs	In Progress	Partner with Other PPSs for Comprehensive Population Health Initiatives	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1 PPS Partnerships	In Progress	1 Foster relationships with other PPS leads to discuss efforts being provided in tobacco use cessation.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2 Shared Campaigns and Initiatives	In Progress	2 Meet with and provide other PPS' assistance and join resources for the creation and dissemination of population wide campaigns and initiatives.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3 Partnerships with City Agencies	In Progress	3 Leverage existing relationship with New York City Department of Health to meet with other PPS' and establish collaborative efforts for	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
		city wide campaigns.						

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Data Analysis	1.2 Hotspot analysis complete.
Develop and Implement Tobacco Use Cessation Protocol	
Educational Campaign	3.1 Protocol provided to physicians during training. 3.3 Treatment plans established
Engage MCOs Regarding Benefit Package	
CBO Support and Resources	
Screening and Treatment Campaign	
Care Coordination Plans	7.2 Protocols provided to physicians.
Success Factors	
Partnerships with Other PPSs	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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DSRIP Implementation Plan Project

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

IPQR Module 4.b.i.3 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

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

Project 4.b.ii – Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings (Note: This project targets chronic diseases that are not included in domain 3, such as cancer

IPQR Module 4.b.ii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

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

ACP recognizes the following risks to this project:
1. Health Literacy. Many PPS patients are of low socio-economic status (SES) and have English as a second language. This leads to gaps in care, since they may not be familiar prevention strategies and lack the economic stability to cover costs. ACP is ready to overcome this challenge in its educational plan to hold population wide campaigns on disease prevention and early detection. Besides the population wide initiatives, ACP providers will follow written protocols for how, when and on whom to perform screening exams as well as whom to provide with preventive care and education. ACP will establish CDSS alerts, run registry reports to send reminders, to provide providers with the tools that they need to engage patients effectively and timely.

2. Provider Culture. Changing the provider internal workflow and culture will be a challenge since new workflows may require more work and more documentation. ACP is prepared to address this using the Support Center to provide on-going training and guidance. Care coordinators and care managers will be available to help facilitate communication and connection between the patient and the providers.

3. Pediatric Patient Engagement. Engaging the parents and educating them in the benefits of vaccination and children about safe sex will be challenging in cultures where there is much taboo around these topics. ACP is prepared to face this challenge by providing education to parents through media, print and engaging the assistance of pharmaceutical companies' expertise in mass education campaigns.

4. Reimbursement. ACP anticipates challenges in patient compliance due to cost. The PPS serves a low income population that cannot absorb the cost of preventive services. ACP will negotiate with MCOs to provide coverage for all preventive services at no cost to the patient as well as with its partners to provide more timely lower cost services. ACP will also establish compliance based incentives for patients such as pink ribbon items, etc.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone CNA Analysis	Completed	ACP analyzed CNA data to understand prevalence of diseases in particular areas. It is developed to achieve primary goal of chronic disease prevention, early detection of chronic disease and early intervention. ACP has the following protocol targets: - Colon Cancer: Colorectal cancer screenings through fecal occult blood yearly, colonoscopy for both sexes at and after 50, every 5 years if negative, and yearly if positive findings are encountered - Breast Cancer: Promote and educate on periodic breast self-exams, provide Mammogram after age 40, every year - Prostate Cancer: Rectal prostate exam at and after age 50, yearly and/or PSA levels - Cervical Cancer: Pap Smears yearly - Lung Cancer: CT scan yearly for smokers - Hepatitis B and C: Safe Sex education and vaccination - HPV: Vaccination promotion for females ages 11 to 26 and males 11-21 -Promote other vaccinations in both children and adults as prescribed by CDC such as Pneumonia, Measles, etc. CNA data indicates an opportunity for optimal cancer management, preventative care and screening protocols. ACP will expand current programs and leverage strengths to respond to these challenges and to meet the project requirements. ACP created a funds model to provide PPS partners with funding to implement high-quality protocols to address gaps in screening and disease management. ACP will use the broad network of providers to provide more education and assist the patient to gain access to preventive services available within their community. This will include collaboration with community-based organizations (CBOs) to identify	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
		locations and resources to best meet the needs of patients. MCO discussions will be broadened to include identification of additional reimbursement models for disease management.						
Task 1 Identify Hotspots	Completed	1 Complete analysis of CNA results to identify "hot spots" of high prevalence of diseases such as Cancer and Hepatitis	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2 Resources Within Hotspots	Completed	2 Complete analysis of CNA to identify resources within the "hot spot"	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone Evidence Based Protocols	In Progress	Create and implement evidence based protocols for prevention and screening for Chronic diseases.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1 Develop Protocol	Completed	1 In conjunction with physician leads and in accordance with national standards develop protocol for screening, educating and providing preventive care to target population.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2 Protocol Criteria	Completed	2 Protocols will stipulate criteria on how, when and on whom to perform screening exams as well as whom to provide with preventive care and education.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 3 Achievement of Goals	In Progress	3 Care Teams and Clinical Quality Committees will review protocol and for compliance with specified ACP project goals in accordance with American Cancer Society and CDC Recommendations: -Colon Cancer: Colorectal cancer screenings through fecal occult blood yearly, colonoscopy for both sexes at and after age 50, every 10 years if negative -Breast Cancer: Promote and educate patient on periodic Breast self exams, and provide Mammogram after age 40, every year and every 2-3 years for women in their 20's and 30's -Prostate Cancer: Starting at age 50, providers should talk to the patient about the pros and cons of testing so they can decide if testing is the right choice for them. For African American men or those who have a father or brother who had prostate cancer before age 65, this talk should start at age 45. If patient agrees to testing, then PSA test and/or Rectal prostate exam shall be performed. -Cervical Cancer: Pap Smears every 3 years -Lung Cancer: CT scan for those who are at high risk of lung cancer due to cigarette smoking. If all of the following: 55 to 74 years of age, In fairly good health, has at least a 30 pack-year smoking history AND is either still smoking or has quit smoking within the last 15 years	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
		-Hepatitis B and C: Safe Sex education and Hep B vaccination -HPV: Vaccination promotion for females ages 11 to 26 and males 11-21 -Promote other vaccinations in both children and adults as prescribed by CDC such as Pneumonia, Measles, etc						
Milestone Target Population	In Progress	Understand Target Population for Engagement	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1 CNA Population Trends	In Progress	1 Drill down CNA results to identify patterns and trends amongst populations. CNA data will be analyzed on algorithms matching neighborhood, culture, ages, immigrant status, primary language, ethnic background to the receipt of preventive services and to disease prevalence.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2 Employ Community Health Workers (CHW)	In Progress	2 Employ Community Health Workers from the communities identified that understand the language and culture. CHWs will be used by ACP to outreach to the population for general outreach and promotion of preventive care.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3 Community Based Organizations	In Progress	3 Identify specific areas of concern and need and utilize community organizations to assist in outreach and development of culturally sensitive educational materials.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 CBO Agreements	In Progress	4 Establish service agreements with CBOs within the target communities to provide care, services and bridge gaps in care.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5 Registries to Target Non-Compliant Population	In Progress	5 Utilize physician EMR registries to target patients who have not had or missed preventive services such as Mammograms, vaccinations, colorectal screenings, etc. This data will be used by ACP, CHWs, CBOs and other outreach staff to ensure patients are connected with their physicians for preventive services.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Milestone Leverage Existing Resources	In Progress	Leverage Existing Resources to Promote Preventive Health	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1 Engage Medical Societies and Other Community Stakeholders	In Progress	1 Establish relationships and work with American Cancer Society, NYC DOH, American Academy of Pediatrics, Community Stakeholders, and Pharmacology Companies on enhancing care and providing population wide educational campaigns on chronic disease prevention.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2 Care Coordinator and CHW Patient Outreach	In Progress	2 Employ care coordinators and community health workers to reach out to patients identified through registries and connect them with PCP and preventive care providers and services.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3 Engage With CBOs	In Progress	3 Identify and establish agreements with community-based organizations (CBOs) to access locations and resources to best meet the needs of patients in providing services and educational campaigns and bridge gaps in care and resources.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4 CBO Education and Outreach	In Progress	4 Leverage agreement with CBOs to provide language and culture appropriate information and service to target patients.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5 MCO Engagement for Incentive Models	In Progress	5 Establish or enhance reimbursement and incentive models with partners and MCOs to increase delivery of high-quality chronic disease prevention and management services. For those services not covered by MCO benefit package, review options regarding 'Services Not Covered' portion of DSRIP budget.	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone Establish Formal Preventive Care Model	In Progress	Negotiate and establish processes in which PPS partners offer recommended clinical preventive services at PPS network sites and connect patients to community-based preventive service resources.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1 Outreach via Community Service Events	In Progress	1 Establish agreements with and assist PPS partners in incorporating prevention agendas into hospital community service plans and events within each physician specialty which will in turn work in an integrated fashion with community based preventive services.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2 Deploy Outreach via Community Service Events	In Progress	2 Incorporate Prevention Agenda goals and objectives into hospital Community Service Plans, and coordinate implementation with local health departments and other community partners.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Milestone Use of EHRs for Clinical Decision Support	In Progress	Adopt and use certified electronic health records, especially those with clinical decision supports and registry functionality.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Clinical Decision Support System (CDSS) and Patient Registries to Identify and Target Patients	In Progress	1 Utilize EMRs to establish CDSS alerts, run registry reports to send reminders, to provide providers with the tools that they need to engage patients effectively and timely.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2 Establish Workflow Steps on Patient Engagement	In Progress	2 Set periodicity for sending recalls and reminders to patients for preventive and follow-up care, and identify community resources available to patients to support disease self-management	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone Medical Home or Team Based Care Models	In Progress	Adopt medical home or team-based care models.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1 Care Team Based Model	In Progress	1 Create a care team based model to ensure whole-person preventive care to patient. Care teams are regional providers who will clinically integrate to deliver care. The PPS will provide	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
		administrative support such as care coordination and care management to ensure care teams, physicians and patients are engaged.						
Task 2 Deploy Care Team Based Model	In Progress	2 Build on care team structure, and work through community and provider engagement teams to strengthen and expand our existing network of medical homes.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone Clinical Benchmarks	In Progress	Establish and provide feedback to clinicians around clinical benchmarks.	01/01/2016	12/31/2017	01/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 1 Align Incentives	In Progress	1 Align incentives with delivery of preventive care as well as outcomes.	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 2 Establish Performance Metrics	In Progress	2 Establish performance metrics to be used for monitoring adherence to protocols and procedures as well as performance. Metric shall include CPT codes obtained from claims data sources such as salient, MCOs denoting procedures performed and billed for comparison data analytics, and data pulls from EMR patient registry data and PCMH and MU level data regarding resulted screenings and vaccinations.	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 3 Establish Monthly Meetings to Understand Performance	In Progress	3 As per ACP governance structure, establish monthly monitoring on all performance measures for project-specific goals. Create reports to distribute to providers to tie performance to desired outcomes.	03/01/2016	06/30/2017	03/01/2016	06/30/2017	06/30/2017	DY3 Q1
Milestone Address Out of Pocket Costs for Patients for Preventive Services	In Progress	Reduce or eliminate out-of-pocket costs for clinical and community preventive services. The PPS is already working with MCOs in enhancing coverage for preventive services	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 1 Engage with MCOs	In Progress	1 PPS will negotiate with partner MCOs in enhancing coverage for preventive services. Leverage existing relationships with MCOs to open discussions regarding broadening the scope of services covered to include additional preventive care services such as vaccines at no cost to patient.	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 2 Engage with Pharmaceuticals	In Progress	2 PPS to negotiate with pharmaceutical companies to provide incentives to patients for compliance, for example providing cost reduction, copay and/or coinsurance assistance for vaccinations.	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Milestone Care Coordination Plans	In Progress	Develop Care Coordination Plans Using Evidence-Based Protocols As Part of the Integrated Delivery System	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1 Establish Centralized Care Management System	In Progress	1 Establish a centralized Care Management system that will have Care Managers, Care Coordinators, Educators and Social Workers and incorporate many aspects of the Medical Home/Team-Based	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
		Models.						
Task 2 Use Centralized CM System for Care Coordination	In Progress	2 Utilize the centralized Care management system to coordinate care across the expansive integrated network of specialty, social services providers, and community stakeholders to ensure all stakeholders participate in the care and compliance of the patients. ACP will also leverage MediSys experienced network of PCMH clinics and expand that model to other areas of the PPS.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3 Centralized System IT	In Progress	3 Integrate Care management as part of IT solution which includes centralized functions, workflows that incorporate the protocols and effective communication channels between partners.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4 System Training	In Progress	4 Provide proper training and education to the workforce to ensure processes are followed and included within partner organizations' workflows.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone Partnerships with Other PPSs	In Progress	Partner with Other PPSs for Comprehensive Population Health Initiatives	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 1 Establish PPS Partnerships	In Progress	1 Identify key personnel in surrounding PPS' and set up negotiations and collaboration/partnerships structure with all PPS' in ACP's geographical area.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2 Develop Shared Initiatives	In Progress	2 Develop and deploy shared initiatives for each PPS that focus on preventive services.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
CNA Analysis	1.1-1.2 CNA complete and hotspots identified. Network resources also identified to assist with project goals in clinical settings.
Evidence Based Protocols	
Target Population	

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Leverage Existing Resources	
Establish Formal Preventive Care Model	
Use of EHRs for Clinical Decision Support	
Medical Home or Team Based Care Models	
Clinical Benchmarks	
Address Out of Pocket Costs for Patients for Preventive Services	
Care Coordination Plans	
Partnerships with Other PPSs	

Module Review Status

Review Status	IA Formal Comments
Fail	The documentation submitted was insufficient to demonstrate completion of the milestone. The PPS failed to submit the CNA analysis as described in the project requirement.

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

Instructions :

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Attestation

The Lead Representative has been designated by the Primary Lead PPS Provider (PPS Lead Entity) as the signing officiate for the DSRIP Quarterly Report. The Lead Representative has the authority to complete this attestation on behalf of the PPS network. The Lead Representative and PPS Lead Entity are responsible for the authenticity and accuracy of the material submitted in this report.

The Lead Representative of the Performing Provider System (PPS) must complete this attestation form in order for the project application to be accepted by the NYS Department of Health. Once the attestation is complete, the Quarterly Report will be locked down from any further editing. Do not complete this section until the entire Quarterly Report is complete.

If the Quarterly Report becomes locked in error and additional changes are necessary, please use the contact information on the Home Page to request that the Quarterly Report be unlocked.

To electronically sign this Quarterly Report, please enter the required information and check the box below:

☐ **I here by attest, as the Lead Representative of the 'Advocate Community Providers, Inc. ', that all information provided on this Quarterly report is true and accurate to the best of my knowledge, and that, following initial submission in the current quarterly reporting period as defined by NY DOH, changes made to this report were pursuant only to documented instructions or documented approval of changes from DOH or DSRIP Independent Assessor.**

Primary Lead PPS Provider:	TALLAJ RAMON MODESTO MD
Secondary Lead PPS Provider:	
Lead Representative:	Mario Paredes
Submission Date:	03/16/2016 01:11 PM

Comments:	

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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	Mario Paredes	mrurak	03/31/2016 05:12 PM
DY1, Q3	Submitted	Mario Paredes	10029	03/16/2016 01:11 PM
DY1, Q3	Returned	Josephine Wu	mrurak	03/01/2016 05:12 PM
DY1, Q3	Submitted	Josephine Wu	jwu139	02/03/2016 07:41 PM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1Q3 Quarterly Report.	mrurak	03/31/2016 05:12 PM
Returned	The IA is returning the DY1Q3 Quarterly Report to the PPS for Remediation.	mrurak	03/01/2016 05:12 PM

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

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

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

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

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

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

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

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

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

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Project ID	Module Name / Milestone #	Review Status	
2.a.i	Module 2.a.i.2 - Prescribed Milestones		
	Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Pass & Complete	
	Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Pass & Ongoing	
	Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Pass & Ongoing	
	Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #7 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.	Pass & Ongoing	
	Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Pass & Ongoing	
	Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Pass & Ongoing	
	Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Pass & Ongoing	
	Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Pass & Ongoing	
2.a.iii	Module 2.a.iii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.a.iii.3 - Prescribed Milestones		
	Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	Pass & Ongoing	
	Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #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.	Pass & Ongoing	
	Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	Pass & Ongoing	
	Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Pass & Ongoing	
	Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Pass & Ongoing	
	Milestone #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).	Pass & Ongoing	
	Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	Pass & Ongoing	
2.b.iii	Module 2.b.iii.2 - Patient Engagement Speed	Fail	
	Module 2.b.iii.3 - Prescribed Milestones		
	Milestone #1 Establish ED care triage program for at-risk populations	Pass & Ongoing	
	Milestone #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	Pass & Ongoing	
	Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Pass & Complete	
	Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Pass & Ongoing	
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Pass & Ongoing	
	Milestone #3 Ensure required social services participate in the project.	Pass & Complete	
	Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Pass & Ongoing	
	Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Pass & Ongoing	
	Milestone #6 Ensure that a 30-day transition of care period is established.	Pass & Ongoing	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Pass & Ongoing	
	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Complete	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.b.i.3 - Prescribed Milestones		
	Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Pass & Ongoing	
	Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Pass & Ongoing	
	Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Complete	
	Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Pass & Ongoing	
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing	
3.c.i	Module 3.c.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.c.i.3 - Prescribed Milestones		
	Milestone #1 Implement evidence-based best practices for disease management, specific to diabetes, in community and ambulatory care settings.	Pass & Ongoing	
	Milestone #2 Engage at least 80% of primary care providers within the PPS in the implementation of disease management evidence-based best practices.	Pass & Ongoing	
	Milestone #3 Develop care coordination teams (including diabetes educators, nursing staff, behavioral health providers, pharmacy, community health workers, and Health Home care managers) to improve health literacy, patient self-efficacy, and patient self-management.	Pass & Ongoing	
	Milestone #4 Develop "hot spotting" strategies, in concert with Health Homes, to implement programs such as the Stanford Model for chronic diseases in high risk neighborhoods.	Pass & Ongoing	
	Milestone #5 Ensure coordination with the Medicaid Managed Care organizations serving the target population.	Pass & Ongoing	
	Milestone #6 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #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.	Pass & Ongoing	
3.d.iii	Module 3.d.iii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.d.iii.3 - Prescribed Milestones		
	Milestone #1 Implement evidence-based asthma management guidelines between primary care practitioners, specialists, and community-based asthma programs (e.g., NYS Regional Asthma Coalitions) to ensure a regional population based approach to asthma management.	Pass & Ongoing	
	Milestone #2 Establish agreements to adhere to national guidelines for asthma management and protocols for access to asthma specialists, including EHR-HIE connectivity and telemedicine.	Pass & Ongoing	
	Milestone #3 Deliver educational activities addressing asthma management to participating primary care providers.	Pass & Complete	
	Milestone #4 Ensure coordination with the Medicaid Managed Care organizations and Health Homes serving the affected	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	population.		
	Milestone #5 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
4.b.i	Module 4.b.i.2 - PPS Defined Milestones	Pass & Ongoing	
4.b.ii	Module 4.b.ii.2 - PPS Defined Milestones	Fail	IA