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

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

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Quarterly Report - Implementation Plan for Central New York Care Collaborative, Inc.

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

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

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
2.d.i	Implementation of Patient Activation Activities to Engage, Educate and Integrate the uninsured and low/non-utilizing Medicaid populations into Community Based Care	Completed
3.a.i	Integration of primary care and behavioral health services	Completed
3.a.ii	Behavioral health community crisis stabilization services	Completed
3.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	Completed
3.g.i	Integration of palliative care into the PCMH Model	Completed
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems	Completed
4.d.i	Reduce premature births	Completed

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget Report

Instructions :

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

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	25,083,509	26,730,777	43,227,021	38,277,362	25,083,509	158,402,178
Cost of Project Implementation & Administration	**23,076,828**	**20,740,410**	**26,623,522**	**22,047,378**	**13,444,761**	105,932,899
Revenue Loss	**2,006,681**	**4,276,924**	**8,645,404**	**6,124,378**	**3,010,021**	24,063,408
Internal PPS Provider Bonus Payments	**0**	**1,712,091**	**7,957,348**	**10,104,983**	**8,628,266**	28,402,688
Cost of non-covered services	**0**	**0**	**0**	**0**	**0**	0
Other	**0**	**0**	**0**	**0**	**0**	0
Total Expenditures	**25,083,509**	**26,729,425**	**43,226,274**	**38,276,739**	**25,083,048**	**158,398,995**
Undistributed Revenue	**0**	**1,352**	**747**	**623**	**461**	**3,183**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

In CNYCC's December 2014 Organizational Application, Budget Category "Cost of Project Implementation" was allocated 20% of funds (as opposed to 67% of funds in the table below), Budget Category "Revenue Loss" was allocated 5% of funds (opposed to 15% of funds in the table below), and Budget Category "Internal PPS Provider Bonus Payments" was allocated 75% of funds (as opposed to 18% in the table below). The majority of this deviation is due to the inclusion of a projected IGT amount within the December application's budget total and within the "Internal PPS Provider Bonus Payments" budget category whereas the amounts below, which are based on estimated not final project valuation, are net of IGT.

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IPQR Module 1.2 - PPS Flow of Funds

Instructions :

In the table below, please detail your PPS's projected flow of DSRIP funds for the next five years, splitting out the flow of funds by provider type. The provider types match the categories used for the Speed & Scale portion of your Project Plan Application.
- This table requires your funds flow projections on an annual basis. Subsequent quarterly reports will require you to submit your actual distribution of funds to these provider categories on a quarterly basis.
- These quarterly submissions of actual funds distribution will ultimately be required at the provider level (as opposed to the provider type level required here)

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	25,083,509	26,730,777	43,227,021	38,277,362	25,083,509	158,402,178
Primary Care Physicians	5,634,283	6,004,294	9,709,697	8,597,899	5,637,283	35,583,456
Non-PCP Practitioners	60,426	64,394	104,134	92,210	60,426	381,590
Hospitals	6,914,846	7,368,953	11,916,523	10,552,035	6,914,846	43,667,203
Clinics	2,481,010	2,643,941	4,275,585	3,786,014	2,481,010	15,667,560
Health Home / Care Management	1,514,618	1,614,085	2,610,177	2,311,302	1,514,618	9,564,800
Behavioral Health	1,828,086	1,948,139	3,150,385	2,789,654	1,828,086	11,544,350
Substance Abuse	914,043	974,070	1,575,193	1,394,827	914,043	5,772,176
Skilled Nursing Facilities / Nursing Homes	58,470	62,309	100,762	89,225	58,470	369,236
Pharmacies	35,418	37,744	61,037	54,048	35,418	223,665
Hospice	39,933	42,555	68,817	60,938	39,933	252,176
Community Based Organizations	585,675	624,137	1,009,308	893,738	585,675	3,698,533
All Other	0	0	0	0	0	0
Total Funds Distributed	**20,066,808**	**21,384,621**	**34,581,618**	**30,621,890**	**20,069,808**	**126,724,745**
Undistributed Revenue	**5,016,701**	**5,346,156**	**8,645,403**	**7,655,472**	**5,013,701**	**31,677,433**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 1.3 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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	In Progress	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.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1. Complete funds flow budget and distribution plan for submission to CNYCC Board/Finance Committee. The funds flow budget and distribution plan will be informed by pro forma results based upon projected amounts and informed estimates.	In Progress	1. Complete funds flow budget and distribution plan for submission to CNYCC Board/Finance Committee. The funds flow budget and distribution plan will be informed by pro forma results based upon projected amounts and informed estimates.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Submit funds flow plan with pro forma distribution to CNYCC Board/Finance Committee for review and approval.	In Progress	2. Submit funds flow plan with pro forma distribution to CNYCC Board/Finance Committee for review and approval.	06/30/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Conduct webinar to present approved funds flow plan to partners.	In Progress	3. Conduct webinar to present approved funds flow plan to partners.	06/30/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. Identify partners that will require technical assistance to participate in funds flow and organize technical assistance in collaboration with other project support activities.	In Progress	4. Identify partners that will require technical assistance to participate in funds flow and organize technical assistance in collaboration with other project support activities.	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

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

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IPQR Module 1.4 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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 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 1.5 - 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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	In Progress	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1A- Develop, recruit, and seat Board of Directors	Completed	1A- Develop, recruit, and seat Board of Directors	04/01/2015	04/02/2015	06/30/2015	DY1 Q1	
Task 1B- Appoint and establish committees, select committee chairs, and adopt committee charters. Committees of the Board include: Executive, Clinical Governance, Compliance, Finance, Nominating, and IT/Data Governance	Completed	1B- Appoint and establish committees, select committee chairs, and adopt committee charters. Committees of the Board include: Executive, Clinical Governance, Compliance, Finance, Nominating, and IT/Data Governance	04/01/2015	05/31/2015	06/30/2015	DY1 Q1	
Task 1C- Establish Regional Project Advisory Committee (RPACs) structure	In Progress	1C- Establish Regional Project Advisory Committee (RPACs) structure	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	In Progress	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 2. Draft and adopt charter for Clinical Governance Committee.	In Progress	2. Draft and adopt charter for Clinical Governance Committee.	04/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task 3. Convene Project Implementation Collaboratives (PICs) for each project. PICs will develop Project Network Plans including CQ plans and monitoring mechanisms. The	In Progress	3. Convene Project Implementation Collaboratives (PICs) for each project. PICs will develop Project Network Plans including CQ plans and monitoring mechanisms. The PICs will report to the Board Clinical Governance Committee on a monthly basis.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
PICs will report to the Board Clinical Governance Committee on a monthly basis.							
Task 4. Provide input from PICs to the Executive PAC and in turn to the Regional PACs monthly.	In Progress	4. Provide input from PICs to the Executive PAC and in turn to the Regional PACs monthly.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1. Appoint and convene Board Clinical Governance Committee.	In Progress	1. Appoint and convene Board Clinical Governance Committee.	04/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	In Progress	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 3A-Develop and approve CNYCC bylaws	In Progress	3A-Develop and approve CNYCC bylaws	04/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task 3B- Develop and approve dispute resolution policies	In Progress	3B- Develop and approve dispute resolution policies	04/01/2015	07/01/2015	09/30/2015	DY1 Q2	
Task 3C- Develop and approve policies and procedures regarding under-performing providers	In Progress	3C- Develop and approve policies and procedures regarding under-performing providers	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3D- Develop and approve CNYCC compliance policies and procedures	In Progress	3D- Develop and approve CNYCC compliance policies and procedures	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	In Progress	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	12/31/2015	DY1 Q3	YES
Task 4A-1. Project Implementation Coollaboratives (PICs) will develop progress metrics, dashboards, and process for monitoring the 11 projects for review and adoption by the CNYCC Board including a schedule for receiving and disseminating data.	In Progress	1. Project Implementation Coollaboratives (PICs) will develop progress metrics, dashboards, and process for monitoring the 11 projects for review and adoption by the CNYCC Board including a schedule for receiving and disseminating data.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Each CNYCC Board Committee and the Workforce Work Group will develop progress	In Progress	2. Each CNYCC Board Committee and the Workforce Work Group will develop progress metrics, dashboards, and reporting schedule for monitoring workforce transformation, financial management, clinical management, and	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
metrics, dashboards, and reporting schedule for monitoring workforce transformation, financial management, clinical management, and IT-Data management.		IT-Data management.					
Task 3. Monthly dissemination of dashboard and monitoring data will flow from the Executive PAC (EPAC) to each Regional PAC (RPAC). Each RPAC will report on data, monitor progress and provide feedback to the EPAC which will in turn inform the Board and Board Committees.	In Progress	3. Monthly dissemination of dashboard and monitoring data will flow from the Executive PAC (EPAC) to each Regional PAC (RPAC). Each RPAC will report on data, monitor progress and provide feedback to the EPAC which will in turn inform the Board and Board Committees.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	In Progress	Community engagement plan, including plans for two-way communication with stakeholders.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 5A-Conduct situational and stakeholder analysis for both internal and external stakeholders, including public and non-provider organizations.	In Progress	5A-Conduct situational and stakeholder analysis for both internal and external stakeholders, including public and non-provider organizations.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5B-Conduct situational and stakeholder analysis for both internal and external stakeholders, including public and non-provider organizations.	In Progress	5B-Conduct situational and stakeholder analysis for both internal and external stakeholders, including public and non-provider organizations.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5C-Develop schedule and budget for communications, including methods for evaluating engagement processes.	In Progress	5C-Develop schedule and budget for communications, including methods for evaluating engagement processes.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5C-Develop schedule and budget for communications, including methods for evaluating engagement processes.	In Progress	5C-Develop schedule and budget for communications, including methods for evaluating engagement processes.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5E-Submit comprehensive Community	In Progress	5E-Submit comprehensive Community Engagement proposal for approval by	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Engagement proposal for approval by the Board of Directors.		the Board of Directors.					
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 6A- Conduct assessment through RPACs and project activities to identify need for contracts with CBOs.	In Progress	6A- Conduct assessment through RPACs and project activities to identify need for contracts with CBOs.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6B-Develop partnership agreements or contracts with key CBOs.	In Progress	6B-Develop partnership agreements or contracts with key CBOs.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6C-Obtain Board approval for CBO partnership agreements or contracts.	In Progress	6C-Obtain Board approval for CBO partnership agreements or contracts	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6D-Execute agreements or contracts with CBOs	In Progress	6D-Execute agreements or contracts with CBOs	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	In Progress	Agency Coordination Plan.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1. Identify and engage key public agencies in region (including Office of Mental Health, County Health Departments, Agencies on Aging, etc.).	In Progress	1. Identify and engage key public agencies in region (including Office of Mental Health, County Health Departments, Agencies on Aging, etc.).	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 1. Engage RPACs to develop agency coordination plan.	In Progress	1. Engage RPACs to develop agency coordination plan.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 1. Finalize agency coordination plan and obtain Board approval.	In Progress	1. Finalize agency coordination plan and obtain Board approval.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #8 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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	NO

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		development of your PPS network.					
Task CNYCC will be contracting with CBOs at the project-specific level. Representatives from potential contracting organizations have been involved in the project Workgroups and understand their roles. The CBO contracting process described above rests on determining readiness and providing support to CBOs to enable their ability to fulfill their roles in each project. Contracts with CBOs will be executed, as appropriate, as each project becomes operational. As we continue to do project planning and begin implementation, we will determine and engage needed CBOs crucial to our success. CNYCC is working with Eric Mower + Associates to develop a comprehensive 1-year engagement plan to assist in this.	In Progress	CNYCC will be contracting with CBOs at the project-specific level. Representatives from potential contracting organizations have been involved in the project Workgroups and understand their roles. The CBO contracting process described above rests on determining readiness and providing support to CBOs to enable their ability to fulfill their roles in each project. Contracts with CBOs will be executed, as appropriate, as each project becomes operational. As we continue to do project planning and begin implementation, we will determine and engage needed CBOs crucial to our success. CNYCC is working with Eric Mower + Associates to develop a comprehensive 1-year engagement plan to assist in this.	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Milestone #9 Finalize workforce communication and engagement plan	In Progress	Workforce communication & engagement plan, including plans for two-way communication with all levels of the workforce, signed off by PPS workforce governance body (e.g. workforce transformation committee).	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1. Work with Workforce team to develop workforce communication and engagement plan.	In Progress	Work with Workforce team to develop workforce communication and engagement plan.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Finalize workforce communication and engagement plan and obtain Board approval.	In Progress	2. Finalize workforce communication and engagement plan and obtain Board approval.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

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

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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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

CNYCC has already seated the Board of Directors, appointed committees & committee chairs, and adopted bylaws. This puts the organization in a strong place with respect to governance going into the implementation phase. It is important that the Board, committees & RPACs focus on broad involvement of and input from the myriad of partners & community members that are impacted by the CNYCC projects.
Risk 1: Lack of active & meaningful participation of the Board of Directors, committees, partners, CBOs and community-at-large in CNYCC governance, planning, implementation, monitoring, and oversight. Potential Impact: The success of CNYCC's DSRIP effort will be dependent on the active & meaningful participation of everyone involved so that 1) CNYCC's efforts are informed by the full breadth of expertise and experience that exists in the region, 2) there is broad investment & buy-in across all partners, and 3) all participants are held accountable for the activities & outcomes that are produced by the CNYCC.

Risk 2: Lack of timely communication & decision-making is a challenge to successful CNYCC governance.
Potential Impact: The CNYCC will make uninformed decisions or miss critical deadlines unless communication can flow freely & efficiently across all partners, particularly to Board members.

Risk 3: The formation of a new non-profit entity requires time and resources to allow members to adapt to new roles & responsibilities, form new relationships, and attend to internal functions, creating inefficiency with respect to monitoring and supporting CNYCC operations. Potential Impact: Without the necessary time & staff resources the CNYCC will not be able to properly embrace its charge, create the necessary infrastructure & operations, and implement effective and efficient projects.

Risk 4: As a new organization, the CNYCC lacks the full breadth of systems (program protocols, financial data management, human resources) necessary to fully support the leadership & functions of the organization. Potential Impact: Without the necessary organizational systems in place, the CNYCC will not be able to appropriately engage its partners & support the development of effective programs.

Risk 5: The need to build stable relationships & trust with partners is essential. Strong partner engagement & communications efforts will be critical to building trust, facilitating collaboration, and ensuring successful project implementation. Potential Impact: Without the appropriate communication & trust, partners will not be fully engaged or informed about what they need to do to participate.

Risk 6: The CNYCC information systems & data tools are immature. Furthermore, technical expertise varies among partners. Potential Impact: Effective information systems will be the primary driver of CNYCC's success. Without effective & efficient information systems, the core elements of CNYCC implementation will not succeed.

Risk 7: The CNYCC will lack strong data governance that will provide a framework in which pertinent clinical information can be aggregated & analyzed for partner and CNYCC performance. Data governance practices for each partner organization vary widely- there is currently no

systematic methodology for documenting & sharing the data that will be required to generate metrics of interest. Potential Impact: Without a strong IT Data Governance structure in place, CNYCC will be unable to generate the necessary metrics for reporting requirements.

Risk 8: CNYCC's professional staff is highly limited and must be developed over a number of months. A new organization involves a learning curve & time period for developing staff cohesion. Potential Impact: Without a strong, cohesive staff, the CNYCC will not be able to support participating partners, create the infrastructure required for success, or meet its state oblig

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

"The Governance workstream depends on most of the other workstreams to be able to fulfill its substantive ongoing policy and monitoring roles.

IT Systems and Processes – Coordination with the IT Systems and Processes workstream will be critical for monitoring clinical and financial performance utilizing real-time data and developing reporting dashboards that feed project and provider specific performance into DSRIP project quality workgroups, Board committees, and the Board of Directors. CNYCC benefits from a cadre of skilled members of the Board's IT and Data-Governance Committee who have extensive experience in IT and with the RHIO.

Performance Monitoring – Coordination with the Performance Monitoring workstream will be critical for monitoring clinical and financial performance utilizing real-time data and developing reporting dashboards that feed project and provider specific performance into DSRIP project quality workgroups, to the Clinical Governance Committee and to the Board of Directors to oversee performance in relation to goals and milestones.

Workforce – The Workforce Workgroup will provide monthly reports to the Board throughout DY1 to ensure that the workforce is deployed appropriately in relation to the projects, that timely training and education is provided so that projects can be staffed appropriately, existing staff can be utilized to the greatest extent possible, and new staff can be brought up to speed quickly. Communication will be maintained with the unions and work force groups that are key stakeholders in the project.

Financial Sustainability and Funds Flow – The Financial Stability and Funds Flow workstreams provide critical information for monitoring the performance of providers so that the Finance Committee and the Board can effectively oversee the financial performance and stability of partners and the organization.

Practitioner Engagement – Coordination with Practitioner Engagement workstream is critical as full implementation of CNYCC is dependent on broad community engagement. This project depends on more than just buy-in; it relies on active championing of change. CNYCC has engaged consulting firms to assist in developing a consumer-engagement plan to promote participation and buy-in. CNYCC has also developed a practitioner engagement strategy with the assistance of a skilled consultant that will be implemented in DY1.
"

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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
Oversight and Approval	CNYCC Board of Directors	Develop and approve policies related to CNYCC operations; monitor performance.
Oversight, Management, and Recommendations to the Board for Approval	Board Committees: Finance, Information Technology and Data Governance, Clinical Governance, and Nominating Committees	Develop performance tracking and information flow procedures; develop and propose policies and procedures to Board for approval; monitor activities and track impact and effectiveness.
Consumer Input and Guidance	Consumer Advocates (TBD)	Provide insight and guidance regarding consumer attitudes, perceptions, and care seeking behaviors potentially through the Regional Project Advisory Councils and Project Implementation Collaboratives
Partner/Consumer Engagement	Regional Project Advisory Councils (RPACs)	The RPACs are the CNYCC Partners' link to the CNYCC staff and Board related to all DSRIP activities. The RPACs provide regional, interactive forum for education, problem solving, project implementation, community and consumer education, and relationship building. The RPACs also respond to queries from the Executive Project Advisory Council (EPAC). The RPAC may also create ad-hoc and/or ongoing smaller committee's to address particular DSRIP activities. Examples could include a committee to problem-solve around a project that is not being successful, or a committee to deep-dive into workforce issue. Staff or Committee representatives would report ongoing CNYCC activies at RPAC meetings.
Bi-directional Information Flow to Projects	Project Implementation Collaboratives	Project Implementation Collabotatives (PICs) will be developed by DY1Q1 that will develop, update, and guide the CNYCC's project implementation planning process overtime with an eye towards meeting state project requirements, implementation of best practice, and broad system transformation.
Management, Oversight, and Expertise	"Kristen Mucitelli-Heath Interim Executive Director CNYCC Staff - TBD "	Execute policies of Board; manage day-to-day operations of the organization; provide support and technical assistance to partners and projects; monitor performance and progress of projects and corporation; report to Board.
Human Resources (HR) and payroll support	Staff Leasing (Vendor)	Support the administration of HR and payroll activities for CNYCC

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		staff
Communications and stakeholder engagement support	Eric Mower and Associates (EMA)	Support related to CNYCC communications and stakeholder engagement.
CNYCC management operations, partner engagement, and funds flow support	John Snow, Inc. (JSI)	JSI is a public health and health care consulting firm that has been engaged by the CNYCC to support project implementation, partner engagement, and general CNYCC operations until CNYCC staff members can be hired.
Partner Engagement, Oversight, and Board Conduit to Partners	Executive Project Advisory Council (EPAC)	The EPAC is the partners' link to the CNYCC BOD. This committee monitors all aspects of the DSRIP process from the Partner perspective. EPAC monitors project performance and quality indicators, considers changes, tracks workforce needs, Partner performance (via review of individual partner, project and regional score cards) and fund distribution. The EPAC responds to queries from the BOD and/or Board Committees as well as communicates to the BOD and/or Board Committees issues/concerns/suggestions from the RPAC's.

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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		
Participating CNYCC provider and CBO Partners	Implementing projects and participating actively on the Board, Board Committees, EPAC, RPACs, and Project Implementation Collaboratives	Effective and efficient project implementation; active involvement in CNYCC governance activities and adherence to CNYCC policies in areas such as security, compliance, health literacy, and cultural competency.
External Stakeholders		
Consumers/Community	Engaging with the projects and organization	Participate in community-based CNYCC activities
Public Agencies – Local, County, State, and Federal	Participating in projects and promoting the organization	Engaging with CNYCC at the organization level to support its goals; participating in project-level activities as providers of services.
Professional/Provider Advocacy Organizations (i.e., HANYS, CHCANYS, NYAPERS, etc.)	Participating in projects and promoting the organization	Engaging with CNYCC

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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.

"Key challenges to implementing IT Governance will be:
1. Striking a balance between the partner individual interests and the interests of the overall CNYCC;
2. Balancing the large number of stakeholders with the need to implement rapidly; and
3. Communication of decisions and reasoning behind those decisions to a large number of stakeholders.

We plan to meet these challenges through an Information Technology and Data Governance Committee of the Board, through workgroups of that Committee and CNYCC staff. The Committee will be made up of Board members to provide alignment with partner priorities and non-Board members to provide information technology expertise and stakeholder collaboration. IT governance will be integrated within the overall governance of CNYCC. Policies related to IT that require Board approval as per the bylaws will be voted upon by the Board. Also it will be a key responsibility of a dedicated CNYCC Chief Information Officer (CIO) to promote appropriate two-way communication with partners. The CNYCC governance structure, including the Board Information Technology and Data Governance Committee, will provide a framework for policy approval and dispute resolution. A representative group of partners will have input and oversight over data sharing policies, confidentiality agreements, access to data by appropriate individuals for approved purposes, and other such issues.

It is also expected that Workgroups will be created to include non-Board IT personnel, subject matter experts, and key stakeholder representatives to set data definitions and interoperability standards, establish policies, and provide timely system performance feedback.
"

IPQR Module 2.8 - Progress Reporting

Instructions :

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

"CNYCC governance success will be measured against timely achievement of the governance milestones. This includes finalizing and establishing the governance structure including development and operation of the Board, committees, and RPACs. Success will also be measured by the timely development and approval of the by-laws, adoption of pertinent policies such as compliance and under-performing provider policies and procedures and reporting processes that enable effective oversight of CNYCC performance.

The Board will require timely and detailed reports to enable them to assess the performance within each workstream and by each project, to identify areas of weakness and oversee development and implementation of corrective action. Through using dashboard and other reporting mechanisms,

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such as MAPP, and establishing rapid response mechanisms the Board will foster a "culture of quality" throughout CNYCC.

The RPACs will focus on project performance and organizational success at the community level. This includes receiving data to monitor progress and performance of the projects in each of their regions. This data will demonstrate progress and performance by project, by provider, and by region. The CNYCC staff as well as subject matter experts will support the projects and RPAC committees. A CNYCC Project Manager who will report progress and performance metrics monthly to the CNYCC Executive Director will staff each of the RPAC committees. The Executive Director will assess the metrics against the project benchmarks and report to the Board's Clinical Quality and Financial Committees. These Committees will assess the progress and make "

IPQR Module 2.9 - IA Monitoring

Instructions :

Milestones #7, 8, and 9 do not have any tasks. These need to be developed and submitted.

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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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	In Progress	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 3. Develop and receive Board approval for organizational and operational plan for CNYCC financial management and reporting, including reporting structure to the Board and oversight committees.	In Progress	3. Develop and receive Board approval for organizational and operational plan for CNYCC financial management and reporting, including reporting structure to the Board and oversight committees.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Appoint CNYCC senior-level personnel to staff finance committee, including identification of DOH compliance and other financial oversight requirements placed on finance committee agenda for discussion and action as needed.	In Progress	4. Appoint CNYCC senior-level personnel to staff finance committee, including identification of DOH compliance and other financial oversight requirements placed on finance committee agenda for discussion and action as needed.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Contract with qualified organization to set up financial cccounting and reporting system and perform accounting and financial reporting functions until established within CNYCC operational structure.	In Progress	5. Contract with qualified organization to set up financial cccounting and reporting system and perform accounting and financial reporting functions until established within CNYCC operational structure.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1. Establish the financial structure of CNYCC and the roles and responsibilities of the Finance	In Progress	1. Establish the financial structure of CNYCC and the roles and responsibilities of the Finance and Compliance Committees.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
and Compliance Committees.							
Task 2. Adopt charge for the CNYCC finance function and establish schedule for Finance Committee meetings.	In Progress	2. Adopt charge for the CNYCC finance function and establish schedule for Finance Committee meetings.	04/01/2015	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 fragile, including those that have qualified as IAAF providers; -- define their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task 2A-Develop list of network partners that self-identified as being at financial risk within the next 12 months	In Progress	2A-Develop list of network partners that self-identified as being at financial risk within the next 12 months	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2B- Identify partners that are IAAF providers.	In Progress	2B- Identify partners that are IAAF providers.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2C- Define the financial indicators that will be used to measure financial stability on an ongoing basis; at a minimum	In Progress	2C- Define the financial indicators that will be used to measure financial stability on an ongoing basis; at a minimum	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2D-Establish benchmarks for each indicator consistent with provider type; i.e. hospitals, community health centers, skilled nursing facilities. Where available, benchmarks will come from industry standards.	In Progress	2D-Establish benchmarks for each indicator consistent with provider type; i.e. hospitals, community health centers, skilled nursing facilities. Where available, benchmarks will come from industry standards.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2E-Create process for collecting financial indicators and incorporate into Decision Support System (DSS).	In Progress	2E-Create process for collecting financial indicators and incorporate into Decision Support System (DSS).	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2F- Establish benchmarks for each indicator consistent with provider type; i.e. hospitals,	In Progress	2F- Establish benchmarks for each indicator consistent with provider type; i.e. hospitals, community health centers, skilled nursing facilities. Where	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
community health centers, skilled nursing facilities. Where available, benchmarks will come from industry standards.		available, benchmarks will come from industry standards.					
Task 2G- Define process for ongoing monitoring and follow-up with partners that show signs of financial risks. Obtain Board	In Progress	2G- Define process for ongoing monitoring and follow-up with partners that show signs of financial risks. Obtain Board	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2H-Develop financial sustainability strategy to address key issues and obtain Board approval.	In Progress	2H-Develop financial sustainability strategy to address key issues and obtain Board approval.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	In Progress	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 2. Establish Compliance Committee of the Board and begin meetings, establish hotline, and hire Compliance Officer.	In Progress	2. Establish Compliance Committee of the Board and begin meetings, establish hotline, and hire Compliance Officer.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Outreach and communication with compliance officers of partners about compliance program partner obligations to participate and comply with compliance program, training and reporting.	In Progress	3. Outreach and communication with compliance officers of partners about compliance program partner obligations to participate and comply with compliance program, training and reporting.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. CNYCC Compliance Officer tasked with developing and carrying out Compliance Plan for CNYCC and its partner organizations that is NYS Social Service Law 363-d.	In Progress	4. CNYCC Compliance Officer tasked with developing and carrying out Compliance Plan for CNYCC and its partner organizations that is NYS Social Service Law 363-d.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1. Board approves Code of Conduct, for CNYCC and partners and Compliance Plan	In Progress	1. Board approves Code of Conduct, for CNYCC and partners and Compliance Plan	04/01/2015	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	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task	In Progress	4A-Survey Medicaid Managed Care Organizations (MCOs) in the region	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
4A-Survey Medicaid Managed Care Organizations (MCOs) in the region regarding the distribution of MCO payments by		regarding the distribution of MCO payments by					
Task 4B- Survey the larger CNYCC health care provider partners by provider type regarding their current use of VBP models	In Progress	4B- Survey the larger CNYCC health care provider partners by provider type regarding their current use of VBP models	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4C- Educate CNYCC partners on VBP options and their comparative merits and risks and solicit input on a preferred approach.	In Progress	4C- Educate CNYCC partners on VBP options and their comparative merits and risks and solicit input on a preferred approach.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4D- Conduct a series of meetings to understand the details of VBP models currently employed by CNY Medicaid MCOs as well as those in development or contemplated.	In Progress	4D- Conduct a series of meetings to understand the details of VBP models currently employed by CNY Medicaid MCOs as well as those in development or contemplated.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4E- Finance Committee drafts VBP transition plan and presents to the Board for approval.	In Progress	4E- Finance Committee drafts VBP transition plan and presents to the Board for approval.	04/01/2015	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	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	YES
Task 5A- Share draft VBP transition plan with CNYCC partners for review and comment, including input on how to achieve 90% value-based payment benchmark. Plan may include partner(s) participation in demonstration payment arrangements with one or more Medicaid MCOs.	In Progress	5A- Share draft VBP transition plan with CNYCC partners for review and comment, including input on how to achieve 90% value-based payment benchmark. Plan may include partner(s) participation in demonstration payment arrangements with one or more Medicaid MCOs.	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 5B- Review draft plan with Medicaid MCOs for review and comment, including participation in demonstration payment arrangements with partner organizations.	In Progress	5B- Review draft plan with Medicaid MCOs for review and comment, including participation in demonstration payment arrangements with partner organizations.	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 5C- Share revised draft with key stakeholders	In Progress	5C- Share revised draft with key stakeholders for review and comment.	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
for review and comment.							
Task 5D- Finance Committee drafts VBP Plan and submits to Board for review and approval.	In Progress	5D- Finance Committee drafts VBP Plan and submits to Board for review and approval.	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	In Progress		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	In Progress		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 to be in Level 2 VBPs or higher	In Progress		04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	
Develop detailed baseline assessment of revenue linked to value-based payment,	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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	

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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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

"Risk 1: As a new organization CNYCC must build a sound financial management and reporting infrastructure.

Potential Impact: CNYCC financial success will depend on having a sound management and reporting infrastructure. Without it CNYCC will not be able to provide the on-going support its partners need, implement sustainable operations, oversee disbursement and expenditure of DSRIP funds, or meet its other obligations to the state.

Risk 2: Success will depend on the creating a new corporation from the ground up, which will be challenging and take time.

Potential Impact: Creating the new corporation will take time and resources, particularly at the outset, which could put CNYCC at a disadvantage as it works to meet the many demanding obligations from the state with respect to project development and implementation.

Risk 3: There may be a delay in distributing DRSIP funds to the partner organizations.

Potential Impact: Participating partners will either not be able to participate or will have to invest their own funds to develop the necessary operations, which could halt operations entirely or delay implementation.

Risk 4: Sharing financial information related to financial viability and developing plans for operational/financial improvement among sometimes competing organizations is often a sensitivity issue. Another risk is the lack of capitalization for providers across the system as they move to VBP contracts with Medicaid MCOs.

"VALUE-BASED PAYMENT
"Transition to Value-Based Payment will present a series of challenges to the CNYCC identified as follows.
"Risk 1: CNYCC will not have the infrastructure it needs to monitor the health status of a population of Medicaid beneficiaries and assume responsibility for the quality and cost of health care services to this population.

Potential Impact: Without this infrastructure CNYCC runs the risk of performing poorly under value-based payment contracts with its Medicaid MCO partners.

Risk 2: Lack of alignment between CNYCC's partner network and the MCO networks.

Potential Impact: Partner contracts and incentives may not be properly aligned between CNYCC and the MCOs, impacting the success of CNYCC in VBP contracts.

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Risk 3: MCOs are wary about what DSRIP means for them, generally have very limited experience with VBP, and no experience working with CNYCC as an entity.

Potential Impact: Medicaid MCOs may not be willing to partner with CNYCC.

Risk 4: Lack of alignment of CNYCC's VBP contracts with the VBP contracts of other Medicare and commercial payers.

Potential Impact: If CNYCC and its partners move to VBP contracts, it may be difficult if the other payer contracts are not aligned with the Medicaid MCO contracts. CNYCC will need to strive for payer contract alignment over time.

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.)

The major dependencies across other workstreams related to Financial Sustainability are IT Systems and Processes, Clinical Integration and Workforce, Performance Reporting, and Governance.

Performance Reporting - CNYCC will implement a Decision Support System (DSS), a PHM platform, and a project management system that are critical to success. This infrastructure will be critical to funds flow and to creating a financial stable, well-governed organization.

Governance - Strong governance will be essential. The Chief Financial Officer (CFO) will report to the Finance Committee of the Board. The Compliance Committee will oversee CNYCC adherence to DSRIP requirements and federal and state laws and regulations related to CNYCC financial reporting and compliance. The Finance Committee will also approve the initial funds flow model and continue to review the model for necessary refinements. The Finance Committee will recommend funds flow model and revisions to the Board for approval and will oversee financial management of DSRIP fund disbursement.

Clinical Integration and Workforce - Clinical Integration and Workforce workstreams are also important dependencies for value-based payment success. Value-based payment, especially when it transitions to downside financial risk in future years, will pose a threat to the financial viability of the CNYCC and its partners unless fundamental changes are made to care delivery processes. These changes need to occur for the vast majority of patients not just for the most ill patients. These changes will include standardizing care processes to eliminate unproductive (and sometimes harmful) variation and waste, and increased and informed use of lower cost and sometimes more productive effective non-physician staff.

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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
Oversight and Approval	CNYCC Board of Directors	Monitor, review and ultimatelly approve funds flow model, CNYCC's financial systems, and operational proforma; monitor funds flow operations
Oversight, Management, and Recommendations to the Board for Approval	Finance and Health Information Technology and Data Governance Committees of the Board	Develop, approve, and recommend funds flow model, CNYCC's financial systems, operational proforma, and finance related policies to the Board; monitor funds flow operations overtime and report to the Board
Consumer Input and Guidance	Consumer Advocates (TBD)	Provide insight and guidance regarding consumer attitudes, perceptions, and care seeking behaviors potentially through the Regional Project Advisory Councils and Project Implementation Collaboratives
Partner Engagement, Oversight, and Board Conduit to Partners	Regional Project Advisory Councils (RPACs)	The RPACs are the CNYCC Partners' link to the CNYCC staff and Board related to DSRIP activities. The RPACs provide regional forums for an interactive process for education, problem solving, project implementation, community and consumer education, and relationship building. The RPACs also respond to queries from the Executive Project Advisory Council (EPAC). The RPAC may also create ad-hoc and/or ongoing smaller committee's to address particular DSRIP activities. Examples could include a committee to problem-solve around a project that is not being successful, or a committee to deep-dive into workforce issue. All committees would be required to formally report out at the monthly RPAC meetings.
Bi-directional Information Flow to Projects	Project Implementation Collaboratives	Project Implementation Collabotatives (PICs) will be developed by DY1Q1 that will develop, update, and guide the CNYCC's project implementation planning process overtime with an eye towards meeting state project requirements, implementation of best practice, and broad system transformation
Management, Oversight, and Expertise	"Kristen Mucitelli-Heath, Interim Executive Director CFO - TBD "	Oversee development and implementation of funds flow, finance operations, development of financial proforma and budgeting, and all finance related activities

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Policy/System development and oversight of finance-related workstreams	Finance Committee of the Board	Directly responsible for the development of CNYCC funds flow policies , financial systems, and operational budget/proforma. Work with staff and consultants to direct, oversee, monitor, and review process and deliverables. Monitor macro-level funds flow from State and SUNY. Make final recommendations to Board of Directors for all finance-related policies, systems, processes, and budget/payments.
Review and comment on funds flow policies made by Finance Committee	Clinical Governance and Health Information Technology and Data Governance Committees of the Board	Review and comment on CNYCC funds flow policis and other relevant finance issues before they are sent too Board of Directors for Final Approval. Monitor funds flow operations overtime and report issues to Finance Committee and Board, as appropriate.
Partner/Consumer Engagement	Regional Project Advisory Councils (RPACs)	The RPACs are the CNYCC Partners' link to the CNYCC staff and Board related to all DSRIP activities. The RPACs provide regional, interactive forum for education, problem solving, project implementation, community and consumer education, and relationship building. The RPACs also respond to queries from the Executive Project Advisory Council (EPAC). The RPAC may also create ad-hoc and/or ongoing smaller committee's to address particular DSRIP activities. Examples could include a committee to problem-solve around a project that is not being successful, or a committee to deep-dive into workforce issue. Staff or Committee representatives would report ongoing CNYCC activities at RPAC meetings.
Partner Engagement, Oversight, and Board Conduit to Partners	Executive Project Advisory Council (EPAC)	The EPAC is the partners' link to the CNYCC BOD. This committee monitors all aspects of the DSRIP process from the Partner perspective. EPAC monitors project performance and quality indicators, considers changes, tracks workforce needs, Partner performance (via review of individual partner, project and regional score cards) and fund distribution. The EPAC responds to queries from the BOD and/or Board Committees as well as communicates to the BOD and/or Board Committees issues/concerns/suggestions from the RPAC's.
Policy/System Development Support and other Technical Assistance as needed	John Snow, Inc and Health Management Associates	Assist the CNYCC Staff and Committees on funds flow policies, finance operations, budgeting/proforma development, and other finance related issues

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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		
All CNYCC Partner Organizations, including service providers and CBOs	Providing information and data to support funds flow distribution	Valid information and data supporting funds flow.
Consumers/Community	Engaging with the projects and organization	Participate in community-based CNYCC activities
External Stakeholders		
Public Agencies – Local, County, State, and Federal	Participating in the projects and promoting the organization	Engaging with CNYCC at the organization level to support its goals; participating in project-level activities as providers of services.
Professional/Provider Advocacy Organizations (i.e., HANYS, CHCANYS, NYAPERS, etc.)	Participating in planning and development of funds flow model	Participating in planning and development of funds flow model
Medicaid Health Plans	Collaborate on development of VBP strategy	Information provided to inform VBP plan and ultimately negotiated contracts with the PPS.

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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.

Shared IT infrastructure will be critical to the Funds Flow and Financial Stability workstreams. CNYCC will implement a Decision Support System (DSS) that will be used to: 1) manage funds flows; 2) facilitate budget planning; and 3) perform rules-based forecasting and modeling. A Project Management System that will be used for partner management, project management, performance management, and reporting will interface with the DSS and PHM platforms to ensure that the CNYCC will be driven by consistent, objective and measureable data. This will ensure that resources are utilized effectively and appropriately by CNYCC. Additionally, in the longer term, CNYCC will establish a comprehensive Population Health Management (PHM) platform to consolidate standardized clinical and administrative data from all eligible partners in order to: 1) centralize reporting functions; 2) perform advanced population health analytics including clinical and financial risk stratification; 3) develop patient registries to track at-risk populations and; 4) coordinate care across the continuum. The integration of claims and clinical data will allow identification of intra-PPS performance variation and cost and quality performance improvement opportunities. The continued use of this platform after the conclusion of the program will ensure that outcomes continue to be monitored and coordinated care delivery will remain in place so that the CNYCC is able to move toward a value-based payment system.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

"Success of CNYCC is dependent on meeting milestones, including developing a finance structure, conducting an assessment, and developing a plan for value-based purchasing (VBP). Key measures of success will be meeting milestones and reporting requirements, as well as feedback from the Board, and Finance Committee regarding performance and operations. Success will be measured through five key measures which include: 1) the CNYCC finance department and finance committees are operational; 2) a Decision Support System (DSS) is operational and being utilized; 3) funds flow payments are being made to partners on timely basis; 4) internal controls are established to oversee funds flow and expenditures; and 5) a written VBP plan that has general buy-in from the partners and health plans and that has been approved by the VBP Sub-committee and Board is in place.
The DSS will support reporting on partner organizations' progress as relates to completing project milestones, funds flow distributions, and financial sustainability indictors. Such reports will be reviewed by the Finance Committee to information future decisions related to necessary changes to the funds flow model.
"

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IPQR Module 3.9 - IA Monitoring

Instructions :

Milestones #6, 7, 8 do not have any tasks. These need to be developed and submitted.

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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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	In Progress	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.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1A- Establish a CC/HL workgroup inclusive of CNYCC partners and community stakeholders to develop the CC/HL strategy.	In Progress	1A- Establish a CC/HL workgroup inclusive of CNYCC partners and community stakeholders to develop the CC/HL strategy.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1B- Compile information from existing community health needs assessment and other data sources to identify target populations that face cultural and linguistic barriers and disparities in outcome	In Progress	1B- Compile information from existing community health needs assessment and other data sources to identify target populations that face cultural and linguistic barriers and disparities in outcome	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1C- Inventory array of best practice interventions and programs to address CC/HL gaps and challenges identified in assessment	In Progress	1C- Inventory array of best practice interventions and programs to address CC/HL gaps and challenges identified in assessment	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 1D- Assess existing CC/HL capacity across CNYCC partner network	In Progress	1D- Assess existing CC/HL capacity across CNYCC partner network	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1E- Develop draft CC/HL strategy.	In Progress	1E- Develop draft CC/HL strategy.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1F- Finalize and receive Board approval of CC/HL strategic plan.	In Progress	1F- Finalize and receive Board approval of CC/HL strategic plan.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	In Progress	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and others as appropriate) regarding specific population needs and effective patient engagement approaches	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task 3. Inventory available training opportunities that meet the identified needs to address health disparities.	In Progress	3. Inventory available training opportunities that meet the identified needs to address health disparities.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Develop training strategy.	In Progress	4. Develop training strategy.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Develop methodology to measure training effectiveness in relation to established goals and objectives.	In Progress	5. Develop methodology to measure training effectiveness in relation to established goals and objectives.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Finalize Training Strategy and obtain Board approval	In Progress	6. Finalize Training Strategy and obtain Board approval	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 1. Collaborate with Workforce Workgroup in the development of training strategy.	In Progress	1. Collaborate with Workforce Workgroup in the development of training strategy.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Assess training needs of diverse segments of the workforce throughout the PPS service area (e.g. clinicians, pharmacists, frontline staff, billing staff, etc.)	In Progress	2. Assess training needs of diverse segments of the workforce throughout the PPS service area (e.g. clinicians, pharmacists, frontline staff, billing staff, etc.)	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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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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	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 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.

The overall goal of improving health literacy and cultural competency is achieved bi-directionally through 1) a system of care delivery that is responsive to the cultures, language and literacy needs of an increasingly diverse patient population, and 2) a community of consumers who have the skills, motivation and trust to access and use the healthcare system that is available to them. Thus, this two-pronged plan will ultimately require interventions within each partner site (i.e. staff training, improving language access services, creating health literate discharge practices, etc.) and also within the community (i.e. community education programs, facilitated two-way communication with health care facilities, etc.). Establishing and maintaining the partnerships and mutual trust needed to achieve this two-way communication is not an easy process. The following are potential risks to achieving this goal and proposed mitigation strategies.
"Risk 1: Partners will not have the time and/or resources to properly implement or participate in the cultural competency and health literacy trainings that will be required to transform provider practice.

Potential Impact: Without sufficient training, CNYCC partners will not be able to be fully responsive to the cultural and linguistic needs of its patients/consumers, potentially decreasing the effectiveness and quality of care that is provided.

"Risk 2: The complexity of the CNYCC network and the sheer number and diversity of organizations that exist across CNYCC partnership create a need for multiple strategies.

Potential Impact: The complexity, size, and diversity of the partnership could lead to a strategy that does not fit everyone's needs and capacities.

"Risk 3: Partnering with the large and diverse group of community partners that will be critical to reaching out to the target population may be a challenge.

Potential Impact: The complexity, size, and diversity of the target population and the program partners that serve the target population could lead to a strategy that does not fit everyone's needs and capacities.

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.)

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"The success of the CC/HL strategy relies heavily on the Workforce and Practitioner Engagement workstreams, and vice versa.

Workforce - Recruiting and hiring trained interpreters, translators, and community health workers, or similar types of service providers who may lead CC/HL efforts, will be essential in promoting and ensuring the goals of CC/HL. Additionally, CNYCC anticipates that CC/HL will be embedded into all hiring and workforce training activities.

Practitioner Engagement - The Practitioner Engagement workstream is also crucial to promoting the enhancement of CC/HL skills and capacities across the practitioner community. Actively engaged practitioners are necessary to achieve a culturally competent CNYCC and health literate community.
"

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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
Oversight and Approval	CNYCC Board of Directors	Develop and approve CC/HL and training strategies and monitor project performance related to CC/HL and reducing disparities among the target populations.
Oversight, Management, and Recommendations to the Board for Approval	Clinical Governance and Health Information Technology and Data Committees	Develop performance tracking and information flow procedures that are relevant to CC/HL; monitor activities and track impact and effectiveness; develop and recommendations to Board regarding CC/HL and training strategies
Consumer Input and Guidance	Consumer Advocates (TBD)	Provide insight and guidance regarding consumer attitudes, perceptions, and care seeking behaviors
Partner Engagement	Regional Project Advisory Councils (RPACs)	The RPACs are the CNYCC Partners' link to the CNYCC staff and Board related to DSRIP activities. The RPACs provide regional forums for an interactive process for education, problem solving, project implementation, community and consumer education, and relationship building. The RPACs also respond to queries from the Executive Project Advisory Council (EPAC). The RPAC may also create ad-hoc and/or ongoing smaller committee's to address particular DSRIP activities. Examples could include a committee to problem-solve around a project that is not being successful, or a committee to deep-dive into workforce issue. All committees would be required to formally report out at the monthly RPAC meetings.
Partner Engagement, Oversight, and Board Conduit to Partners`	Executive Project Advisory Council	The EPAC is the partners' link to the CNYCC BOD. This committee monitors all aspects of the DSRIP process from the Partner perspective. EPAC monitors project performance and quality indicators, considers changes, tracks workforce needs, Partner performance (via review of individual partner, project and regional score cards) and fund distribution. The EPAC responds to queries from the BOD and/or Board Committees as well as communicates to the BOD and/or Board Committees issues/concerns/suggestions from the RPAC's.
Bi-directional Information Flow to Projects	Project Implementation Collaboratives	Project Implementation Collabotatives (PICs) will be developed by DY1Q1 that will develop, update, and guide the CNYCC's project

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		implementation planning process overtime with an eye towards meeting state project requirements, implementation of best practice, and broad system transformation
Focused expertise and support across a representative group of partners and stakeholders	CC/HL Workgroup	Responsible for developing CC/HL Strategic Plan.
Management, Oversight, and Expertise	"Kristen Mucitelli-Heath, Interim Executive Director CNYCC Program Manager(s)"	Oversee development and implementation of strategies for cultural competence and health literacy.

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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		
CNYCC Workforce Working group	Participate and collaborate in CC/H: and Training strategy development	Participate in assessment, planning, and training activities
All CNYCC Partner Organizations, Including Service Providers and CBOs	Partners with respect to service provision, community education and/or training activities	"Participate in projects, Share CC/HL resources Serve as CC/HL training other CC/HL resources "
Consumers/Community	Engaging with the projects and organization	Participate in community-based CNYCC activities
External Stakeholders		
Local School Districts and Other Educational Institutions Including Community Colleges	Potential partner in community education and/or training activities	Share CC/HL resources; possibly serve as CC/HL trainers.
Organizations and Agencies Serving Refugees and New Immigrants	Potential partner in community education and/or training activities	Share CC/HL resources; possibly serve as CC/HL trainers.
Adult Education Programs Including Job Training and English for Speakers of Other Languages	Potential partner in community education and/or training activities	Share CC/HL resources; possibly serve as CC/HL trainers.
WIC Programs, Senior Centers and Other Health and Social Services Programs	Potential partner in community education and/or training activities	Share CC/HL resources; possibly serve as CC/HL trainers.
Libraries Including Public Libraries, School-based and Health Care Consumer and Medical Libraries	Potential partner in community education and/or training activities	Share CC/HL resources; possibly serve as CC/HL trainers.
AHECs and other local programs offering education and promotion programing	Potential partner in community education and/or training activities	Share CC/HL resources; possibly serve as CC/HL trainers.
NY State department of public health, office of minority health, county/local health agencies, and other governmental agencies	Potential partner in community education and/or training activities	Share CC/HL resources; possibly serve as CC/HL trainers.

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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.

In order to effectively address the drivers of health disparities, CNYCC will need to identify the disparities that exist, as well as understand the populations that they impact. A shared IT infrastructure will support the identification of health disparities by enabling the aggregation of data from across localities and healthcare sectors, as well as the systematic analysis of that data to identify trends. Demographic, socio-economic and health literacy data that is captured and shared through this same infrastructure will allow CNYCC to characterize the populations that are most affected by these disparities, which will lead to developing interventions that are culturally appropriate. In addition, the CNYCC website will serve as a forum for sharing information and resources about CC/HL with all CNYCC partners. This will include maintaining an inventory of CC/HL resources that can be easily accessed as well as promoting CC/HL trainings.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

CNYCC success is dependent on reaching two milestones related to CC/HL: the development of an overarching CC/HL strategy and training plan. The measure of success for this workstream is integrated with the larger goal of evolving the CNYCC toward a population health orientation that is person-focused. Understanding health disparities is critical to realizing this goal and CC/HL is a fundamental strategy for addressing these health disparities. Key measures of success will be meeting milestones and reporting requirements, as well as feedback from the Board regarding performance. Key indicators include progress in developing the strategies, which will ultimately receive Board approval.

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	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.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1A- Work with CNYCC project teams to incorporate Health Information Technology (HIT) needs into detailed project plans – functional requirements identified.	In Progress	1A- Work with CNYCC project teams to incorporate Health Information Technology (HIT) needs into detailed project plans – functional requirements identified.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1B- Work with CNYCC project teams to incorporate Health Information Technology (HIT) needs into detailed project	In Progress	1B- Work with CNYCC project teams to incorporate Health Information Technology (HIT) needs into detailed project	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Complete detailed provider HIT readiness assessment using surveys and provider specific follow-up, including the following information: EHR/practice management system use (including vendors and versions); HIE/RHIO participation; meaningful use (MU)/PCMH status; Direct Exchange capabilities; workflow automation capabilities; IT systems infrastructure including security systems and safeguards (including support staff/services).	In Progress	3. Complete detailed provider HIT readiness assessment using surveys and provider specific follow-up, including the following information: EHR/practice management system use (including vendors and versions); HIE/RHIO participation; meaningful use (MU)/PCMH status; Direct Exchange capabilities; workflow automation capabilities; IT systems infrastructure including security systems and safeguards (including support staff/services).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 1D- Develop plans to assist community providers in accessing and providing EHR solutions.	In Progress	1D- Develop plans to assist community providers in accessing and providing EHR solutions.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1E- Complete gap analysis comparing current state assessment to required inputs, required functionality, and intended outputs.	In Progress	1E- Complete gap analysis comparing current state assessment to required inputs, required functionality, and intended outputs.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 1F- Build roadmap including an HIT acquisition and implementation plan for all identified gaps.	In Progress	1F- Build roadmap including an HIT acquisition and implementation plan for all identified gaps.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 1G- Obtain Board approval for HIT/HIE roadmap	In Progress	1G- Obtain Board approval for HIT/HIE roadmap	04/01/2015	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	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 2A1. Determine CNYCC organizational vision, commitment, capabilities, and desired future state	In Progress	1. Determine CNYCC organizational vision, commitment, capabilities, and desired future state	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2B2. Choose/create/customize Change Management Toolkit.	In Progress	2. Choose/create/customize Change Management Toolkit.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2C3. Create Board IT and Data Governance Committee.	In Progress	3. Create Board IT and Data Governance Committee.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2D4. Hold IT and Data Governance Committee meetings, organize and establish priorities, roles and responsibilities, including change management oversight and performance metrics.	In Progress	4. Hold IT and Data Governance Committee meetings, organize and establish priorities, roles and responsibilities, including change management oversight and performance metrics.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 2E5. Create IT decision-making model, including communication and escalation processes.	In Progress	5. Create IT decision-making model, including communication and escalation processes.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2F6. Establish data governance structure, guiding principles, priorities, and roles and responsibilities.	In Progress	6. Establish data governance structure, guiding principles, priorities, and roles and responsibilities.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2G7. Develop plans to communicate and educate stakeholders as appropriate.	In Progress	7. Develop plans to communicate and educate stakeholders as appropriate.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2H8. Obtain Board approval of IT Governance and Data Governance plans.	In Progress	8. Obtain Board approval of IT Governance and Data Governance plans.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2I9. Elicit feedback from partner organizations to understand their change management readiness, commitment, and capabilities.	In Progress	9. Elicit feedback from partner organizations to understand their change management readiness, commitment, and capabilities.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 10. Develop Impact/Risk Assessment.	In Progress	10. Develop Impact/Risk Assessment.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 11. Develop training plan.	In Progress	11. Develop training plan.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 12. Obtain Board approval for change management strategy and policies and publish approved plan.	In Progress	12. Obtain Board approval for change management strategy and policies and publish approved plan.	04/01/2015	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 management records (completed subcontractor DEAAs with all Medicaid providers within the PPS; contracts	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).					
Task 1. Present Data Sharing roadmap requirements to the IT and Data Governance Committee and establish workgroups to develop sections of the roadmap including; Data sharing rules and enforcement via governance; Technical standards for a common clinical data set; training plan.	In Progress	1. Present Data Sharing roadmap requirements to the IT and Data Governance Committee and establish workgroups to develop sections of the roadmap including; Data sharing rules and enforcement via governance; Technical standards for a common clinical data set; training plan.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3B- Develop and present Data Sharing Roadmap components to IT and Data Governance Committee including: HIE and	In Progress	2. Develop and present Data Sharing Roadmap components to IT and Data Governance Committee including: HIE and data sharing current state assessment; data sharing rules and enforcement strategy; proposed technical standards for a common clinical data set; proposed training plan.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3C- Obtain Board approval for Data Sharing Roadmap.	In Progress	3C- Obtain Board approval for Data Sharing Roadmap.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3AA- Develop CNYCC policies and standards requiring appropriate BAA and DEAA documentation and the necessary	In Progress	3AA- Develop CNYCC policies and standards requiring appropriate BAA and DEAA documentation and the necessary	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3BB- Develop data sharing partner onboarding process, forms and procedures.	In Progress	3BB- Develop data sharing partner onboarding process, forms and procedures.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3CC- Establish and present proposed plan to obtain data exchange agreements by all providers, as well as standard	In Progress	3CC- Establish and present proposed plan to obtain data exchange agreements by all providers, as well as standard	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3DD- Obtain Board approval for Data Sharing Agreement Plan.	In Progress	3DD- Obtain Board approval for Data Sharing Agreement Plan.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3AAA- Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange.	In Progress	3AAA- Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3BBB- Prioritize partners/vendor engagements	In Progress	3BBB- Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
with top priority to those currently capable and willing to participate in standards compliant exchange.							
Task 3CCC- Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange.	In Progress	3CCC- Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3DDD- Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based	In Progress	3DDD- Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3EEE- Obtain Board approval for Data Sharing Rollout Plan.	In Progress	3EEE- Obtain Board approval for Data Sharing Rollout Plan.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	In Progress	PPS plan for engaging attributed members in Qualifying Entities, signed off by PPS Board. The plan should include your approach to outreach into culturally and linguistically isolated communities.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 4A-1. Compile information from existing community health needs assessment and other data sources to identify target populations that face cultural and linguistic barriers and disparities in outcomes	In Progress	1. Compile information from existing community health needs assessment and other data sources to identify target populations that face cultural and linguistic barriers and disparities in outcomes	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4B- 2. Work with cultural competency workgroup and the IT and Data Governance Committee (includes representative from local QE) to inventory HIT related strategies/workflows to engage target populations including: channels of communication; modes of communication; required HIT system support	In Progress	2. Work with cultural competency workgroup and the IT and Data Governance Commiitee (includes representative from local QE) to inventory HIT related strategies/workflows to engage target populations including: channels of communication; modes of communication; required HIT system support	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Inventory best practices for supporting	In Progress	3. Inventory best practices for supporting identified HIT related cultural compentency strategies into existing technologies/workflows (e.g. partner	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
identified HIT related cultural compentency strategies into existing technologies/workflows (e.g. partner EMRs, patient portals), new technologies identified in HIT Roadmap (e.g. PHM platform) and workflows (e.g. QE consent, patient education)		EMRs, patient portals), new technologies identified in HIT Roadmap (e.g. PHM platform) and workflows (e.g. QE consent, patient education)					
Task 4. Assess CNYCC's partner's ability to adopt and implement identified best practices	In Progress	4. Assess CNYCC's partner's ability to adopt and implement identified best practices	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Work with IT and Data Governance Committee and cultural competency worgkroup to finalize engagement plans, including: identifying appropriate touch-point for the target populations; existing policies and procedures in place at partner organizations that can be leveraged (e.g. QE consent); required changes to new and existing technologies based on identified capabilities	In Progress	5. Work with IT and Data Governance Committee and cultural competency worgkroup to finalize engagement plans, including: identifying appropriate touch-point for the target populations; existing policies and procedures in place at partner organizations that can be leveraged (e.g. QE consent); required changes to new and existing technologies based on identified capabilities	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop a data security and confidentiality plan.	In Progress	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task 5A- Develop initial CNYCC Information Security and Privacy Policies to receive and manage Medicaid Claims Data; develop inventory of other Security and Privacy Policies needed.	In Progress	5A- Develop initial CNYCC Information Security and Privacy Policies to receive and manage Medicaid Claims Data; develop inventory of other Security and Privacy Policies needed.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5B- Identify technical standards and protocols for CNYCC and partner organizations in relation to data shared for CNYCC purposes.	In Progress	5B- Identify technical standards and protocols for CNYCC and partner organizations in relation to data shared for CNYCC purposes.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5C- Identify and inventory security/privacy officer responsible for CNYCC security practices and management at each	In Progress	5C- Identify and inventory security/privacy officer responsible for CNYCC security practices and management at each	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task	In Progress	5D- Develop initial risk assessment and analysis which may include, but not	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
5D- Develop initial risk assessment and analysis which may include, but not be limited to, surveys of security and privacy practices at partner organizations, requesting partner organizations to conduct a security and privacy risk analysis and resulting remediation as well as requests for any other information required to assess or promote compliance with CNYCC security and privacy safeguards, and the Security and Privacy Policies and Procedures.		be limited to, surveys of security and privacy practices at partner organizations, requesting partner organizations to conduct a security and privacy risk analysis and resulting remediation as well as requests for any other information required to assess or promote compliance with CNYCC security and privacy safeguards, and the Security and Privacy Policies and Procedures.					
Task 5E- Develop data security and confidentiality communication plan including protocols and training materials for partner organization security officers.	In Progress	5E- Develop data security and confidentiality communication plan including protocols and training materials for partner organization security officers.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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	
Develop a specific plan for engaging attributed members in Qualifying Entities	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a data security and confidentiality plan.	

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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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Risk 1: Data governance practices for each partner organization vary widely, and there is currently no systematic methodology for documenting and sharing the data that will be required to generate metrics of interest. Key challenges to implementing IT Governance will be: 1) striking a balance between the interests of individual partners and the interests of the overall CNYCC and 2) communication of decisions and reasoning behind those decisions to a large number of stakeholders.

Potential Impact: Without a strong IT Data Governance structure in place, CNYCC will be unable to generate the necessary metrics for reporting requirements.

Risk 2: A challenge will be to balance the large number of partners with the need to implement rapidly.

Potential Impact: If there is a lack of coordination across partners, projects will not be implemented in alignment. This will impact the efficiency by which projects can be implemented.

Risk 3: Given the newness of CNYCC as an entity, it is necessary to efficiently establish infrastructure to support data security and confidentiality.

Potential Impact: Data security and confidentiality is critical to meeting ethical and regulatory regulations surrounding data sharing.

Risk 4: Given the large amount of data that has to be aggregated and analyzed to drive CNYCC operations and facilitate safe care transitions across the continuum, there are risks associated with the number of vendors that are represented in the CNYCC and their varying capabilities as it relates to interoperability. Additionally, there are risks associated with varying documentation practices across the partners that may lead to inconsistencies in the type or amount of data that is captured by each partner.
Potential Impact: Lack of data standardization will lead to delay in useful analytics.

Risk 5: There are competing priorities and resource constraints for partner organizations.

Potential Impact: If partners feel that the resources they have do not enable them to meet DSRIP project requirements they may not prioritize implementation of DSRIP projects.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

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Instructions :

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

Workforce – We will need to ensure that the workforce is adequately trained on new technologies and their associated functionality in order to ensure effective utilizations of the HIT solutions that are introduced as part of DSRIP. We will also need to ascertain partner capabilities with respect to tracking and delivering required training through a Learning Management System, or other data collection and reporting platform.

Financial Sustainability – Significant new applications will be required for the CNYCC. Initial system cost, implementation, and ongoing maintenance will be a significant portion of the CNYCC budget. The cost effectiveness of the IT solution will have a significant impact on the sustainability of the CNYCC.

Cultural Competency/Health Literacy – IT applications will need to be built to gather data that will identify cultural and health literacy factors such as language. Communication to attributed members generated from CNYCC IT applications may need to be sent in multiple languages and sensitive to cultural norms.

Population Health Management- All CNYCC projects are expected to need to leverage the Population Health Management infrastructure. As such, it will be important to map the project requirements against the chosen PHM system. Implementation of the system will similarly affect rollout timelines for each project.

Clinical Integration –The foundation provided by the HealtheConnections RHIO will provide CNYCC a significant head start toward integration. However, CNYCC is concerned about aligning requirements for the multiple EHRs from multiple vendors. This is expected to be an ongoing challenge. Use cases and processes that are defined as part of clinical integration will also serve as a driving force for IT solutions development.

Performance Reporting- CNYCC's ability to systematically generate consistent, dependable metrics to track performance improvement on aggregate and at the partner level will be heavily dependent on HIT. Specifically, the development of an HIT infrastructure to support data collection and aggregation, as well as strong data governance to ensure documentation and data standards are upheld among collaborating partners.

Practitioner Engagement- The requirement for partners to meet Meaningful Use and PCMH certification will be heavily dependent on practitioner adoption of new and existing technologies within each partner organization. In addition, the cost of the IT systems and resources required to achieve these certifications may be a significant barrier to practitioner buy-in.

Budget and Funds Flow – CNYCC will be creating a decision support system (DSS) that will enable them to: manage funds flow; facilitate budget planning; and perform rules based forecasting and modeling. Used in conjunction with the performance data available through the MAPP tools provided by the State, as well as through the PHM platform, the DSS will enable the systematic alignment of incentives with performance.

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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
Oversight and Approval	CNYCC Board of Directors	Approve budgets, expenditures, and key policies; assure regulatory compliance, IT governance oversight.
Oversight, Management, and Recommendations to Board for Approval	Information Technology and Data Governance Committee	Obtain consensus on system selection and management, policy formation, dispute resolution, change management oversight, security and risk management oversight, progress reporting.
Consumer Input and Guidance	Consumer Advocates (TBD)	Provide insight and guidance regarding consumer attitudes, perceptions, and care seeking behaviors
Partner input, technical input	Project Implementation Collaboratives	Develop system recommendations, project management, ongoing reporting.
Operational Management	CIO and Security Officer	Operation responsibility, implementation responsibility, data security responsibility, change management, data architecture definition, data security, confidentiality, data exchange standards definition, risk management, progress reporting.
Advisory and operational	CEO, CFO, CMIO, CNO of hospitals and other partner organizations	Provide input on impact of key CNYCC policies and decisions on partners. Implement internal changes in partner organizations needed to achieve DSRIP goals.
Advisory and operational	HealtheConnections RHIO Director and staff	Provide input on impact of key CNYCC policies and decisions on the RHIO. Implement RHIO changes needed to achieve DSRIP goals. Data architecture, data security, confidentiality, data exchange input and operational responsibilities.
Advisory and operational	Vendors who provide technical input, and implementation support	Supply tools to enable outreach and analysis.

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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		
All CNYCC Partner Organizations, including service providers and CBOs	Advisory, operational, technical input	Provide input on impact of key CNYCC policies and decisions on partners. Implement internal changes in partner organizations needed to achieve DSRIP goals.
HeC RHIO	Operational, technical input, advisory	Provide input on impact of key CNYCC policies and decisions on the RHIO. Implement RHIO changes needed to achieve DSRIP goals. Data architecture, data security, confidentiality, data exchange, input and operational responsibilities.
Consumers/Community	Engaging with the projects and organization	Participate in community-based CNYCC activities
External Stakeholders		
Vendors	"Technical input Advisory Regulatory "	Various activities based on scope of work and needs of CNYCC
Public Agencies – Local, County, State, and Federal	Participating in the projects and promoting the organization	Engaging with CNYCC at the organization level to support its goals; participating in project-level activities as providers of services. Provide advice, guidance, and decisions.

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

CNYCC success is dependent on reaching a series of milestones related to assessment and change management, as well as strategic planning with respect to data sharing, interoperability, and data security/confidentiality. The measure of success for this workstream is integrated with the larger goal of evolving the CNYCC toward a population health orientation that is person-focused. Assessing and developing strategies and change management plans that will allow partners and the CNYCC to collect, analyze, share, use patient information to manage the health of those in the service area is critical to realizing CNYCC goals. Success will rely on the following factors: 1) the CNYCC's HIT Department and Information Technology and Data Governance Committee is operational and working with the Clinical Governance Committee, the RPACs/EPAC, the Board of Directors, and other governance and oversight structures; 2) a Decision Support System (DSS) is operational and being utilized; 3) that patient, project-level, and CNYCC-level information is flowing between partners and to the CNYCC on a timely basis; 4) internal controls are established to oversee partner HIT/HIE related achievements, and 5) the development of sound plans with respect to data sharing, interoperability, and data security/confidentiality. The CNYCC will develop or use existing required measures in these areas and report on performance related to these measures.

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	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	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1. Map out performance reporting requirements by project, by locus of reporting responsibilities by organization type, by commonalities across project and across organization type.	In Progress	1. Map out performance reporting requirements by project, by locus of reporting responsibilities by organization type, by commonalities across project and across organization type.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Develop short-term strategy for reporting for organizations engaging patients in DY1 (before Project Management Platform is in place).	In Progress	2. Develop short-term strategy for reporting for organizations engaging patients in DY1 (before Project Management Platform is in place).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Develop long-term strategy for performance reporting and partner/CNYCC communications (including identification of individuals responsible for clinical and financial outcomes of specific patient pathways, plans for the creation and use of clinical quality & performance dashboards, and approach to rapid cycle evaluation). Additionally, the strategy will include how to collect metrics that	In Progress	3. Develop long-term strategy for performance reporting and partner/CNYCC communications (including identification of individuals responsible for clinical and financial outcomes of specific patient pathways, plans for the creation and use of clinical quality & performance dashboards, and approach to rapid cycle evaluation). Additionally, the strategy will include how to collect metrics that will not be available through DOH or the MAPP system.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
will not be available through DOH or the MAPP system.							
Task 4. Develop specifications of Project Management Platform.	In Progress	4. Develop specifications of Project Management Platform.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Assess vendor products.	In Progress	5. Assess vendor products.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Purchase and install Project Management Platform.	In Progress	6. Purchase and install Project Management Platform.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Train CNYCC staff on Project Management Platform.	In Progress	7. Train CNYCC staff on Project Management Platform.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Train and on-board necessary partners to use Project Management Platform.	In Progress	8. Train and on-board necessary partners to use Project Management Platform.	04/01/2015	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	03/31/2016	DY1 Q4	NO
Task 2A- Conduct webinar for short-term project reporting (instructions and timelines).	In Progress	2A- Conduct webinar for short-term project reporting (instructions and timelines).	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2B- Post instructions and timelines for short-term project reporting on CNYCC website.	In Progress	2B- Post instructions and timelines for short-term project reporting on CNYCC website.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2C- Provide technical assistance to organizations that may be having difficulties.	In Progress	2C- Provide technical assistance to organizations that may be having difficulties.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2D- Develop initial training program focused on clinical quality and performance reporting.	In Progress	2D- Develop initial training program focused on clinical quality and performance reporting.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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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.	

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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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. CNYCC staff, led by the Medical Director with guidance from the Clinical Governance Committee of the Board, will work with the Project Implementation Collaborative (PIC) for this project to develop and implement a comprehensive Quality/Performance Improvement Plan (QPIP).	In Progress	CNYCC staff, led by the Medical Director with guidance from the Clinical Governance Committee of the Board, will work with the Project Implementation Collaborative (PIC) for this project to develop and implement a comprehensive Quality/Performance Improvement Plan (QPIP).	10/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 1a: The QPIP will mandate the development of project dashboard, which will include the State' required measures as well as other measures deemed appropriate by the PIC	In Progress	The QPIP will mandate the development of project dashboard, which will include the State' required measures as well as other measures deemed appropriate by the PIC	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1b. The QPIP will outline PPS expectations related to the implementation of robust continuous quality improvement (CQI)/Rapid Cycle Evaluation (RCE) principles	In Progress	The QPIP will outline PPS expectations related to the implementation of robust continuous quality improvement (CQI)/Rapid Cycle Evaluation (RCE) principles	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1c. The Project QPIP will be monitored by the PPS' Medical Director, the PIC, the Regional Project Advisory Councils, the Executive Project Advisory Council, the Clinical Governance Committee of the Board, and ultimately the PPS Board of Directors.	In Progress	The Project QPIP will be monitored by the PPS' Medical Director, the PIC, the Regional Project Advisory Councils, the Executive Project Advisory Council, the Clinical Governance Committee of the Board, and ultimately the PPS Board of Directors.	10/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 1d. The PPS will conduct trainings on a regular basis that will educate partners on CQI/RCE principles and instill in partners the importance of using data and HIT systems in a meaningful	In Progress	The PPS will conduct trainings on a regular basis that will educate partners on CQI/RCE principles and instill in partners the importance of using data and HIT systems in a meaningful way to monitor and improve quality and performance.	10/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
way to monitor and improve quality and performance.						

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. CNYCC staff, led by the Medical Director with guidance from the Clinical Governance Committee of the Board, will work with the Project Implementation Collaborative (PIC) for this project to develop and implement a comprehensive Quality/Performance Improvement Plan (QPIP).	

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

Instructions :

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

Risk 1: Although the need has been identified and preliminary specifications have been developed, there has not been the opportunity to invest in a Project Management Platform given the newness of formation of the CNYCC management organization. CNYCC will have the need for a short-term performance reporting system to capture DY1 partner involvement and patient engagement before a more permanent, longer-term project reporting system is in place.

Potential Impact: If CNYCC does not have a short-term strategy for performance reporting, there is a potential that CNYCC will miss initial patient engagement and fall short of early speed and scale goals.

Risk 2: One critical purpose of the performance reporting workstream is to build capacity and data use to improve quality and develop a culture of quality across the CNYCC through using data and rapid cycle evaluation. However, the learning curve for reporting data and the sheer number of data elements that need to be reported draw capacity away from using the data to inform quality improvement and for rapid cycle evaluation. Thus, there is a risk that partners will become more focused on reporting details than on developing a "culture of quality".

Potential Impact: To fall short on developing this culture of quality will mean that data collection becomes only a burden to partners and CNYCC without the value of using and acting upon data to drive quality improvement.

Risk 3: Although there will be a wealth of metrics available through the DOH to assess clinical quality, there are some metrics required for tracking that are not available through DOH. The CNYCC will use its Population Health Management (PHM) Platform to capture these metrics; however, the risk is in being able to collect these metrics from the partners. As with all reporting requirements, organizational capacity will play a role. Organizational capacity is dependent on organizational resources available, organizational leadership commitment, and organizational culture (most notably, how far along the path an organization is to having a "culture of quality").

Potential Impact: If CNYCC falls short on accurately collecting and reporting this subset of metrics, there is a risk that CNYCC will not achieve its performance goals.

Risk 4: Diversity in organizational and staff capacity to report on performance and conduct quality improvement: Some organizations will be very sophisticated regarding these activities and others will be less so. Additionally, staff members within organizations learn in different ways.

Potential Impact: Such diversity is a challenge when it comes to training. If CNYCC assumes the same training will be effective for all partners, some partners will become unengaged, and other partners will not have the information they need to improve quality outcomes and next quality goals.

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IPQR Module 6.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

"Performance Reporting will have interdependencies with all projects and the funds flow, information technology systems and processes, workforce, and governance workstreams.

IT Systems and Processes - The IT systems and processes workstream are interdependent with performance reporting given that the Project Management Platform will be used to collect and report out on the performance metrics. The Project Management Platform will be used to generate dashboards for partners as a quality improvement tool; developing the reporting capacity within the system for these dashboards will fall largely to the IT systems and processes workstream. Additionally, Domain 2 and 3 measures will be available through the State's Salient platform and will be integrated into the Project Management Platform for reporting "down" from the CNYCC staff to partners. The Project Management Platform used must also be consistent and compatible with the State's MAPP system.

Funds Flow - Performance reporting is interdependent with funds flow because a critical strategy within funds flow is to issue payments to partners based on performance. Additionally, there must be compatibility between the Project Management Platform and the Decision Support System, which will calculate funds flow to partners based, in part, on performance reporting.

Workforce - The workforce workstream and performance reporting are interdependent given the large training component within performance reporting. All CNYCC training falls under the auspices of the workforce workstream.

Governance - The governance and performance reporting workstreams are also interdependent in that the Board and its committees will be using data generated through performance reporting to assess progress of the CNYCC toward meeting its goals and using data to conduct rapid cycle evaluation at the CNYCC level. "

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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
Oversight and Approval	CNYCC Board of Directors	Develop and approve performance monitoring and reporting systems and infrastructure
Oversight, Management, and Recommendations to the Board	Clinical Governance and HIT Committees of the Board	"Develop performance tracking and information flow procedures that are relevant to performance measurement and reporting; monitor activities and track impact and effectiveness Provide vision and leadership to promote culture of excellence and vision of population health. Leverage clinical strengths and address clinical weaknesses to improve population health across CNYCC. "
Consumer Input and Guidance	Consumer Advocates (TBD)	Provide insight and guidance regarding consumer attitudes, perceptions, and care seeking behaviors
Partner Engagement, Oversight, and Board Conduit to Partners	Regional Project Advisory Councils (RPACs)	The RPACs are the CNYCC Partners' link to the CNYCC staff and Board related to DSRIP activities. The RPACs provide regional forums for an interactive process for education, problem solving, project implementation, community and consumer education, and relationship building. The RPACs also respond to queries from the Executive Project Advisory Council (EPAC). The RPAC may also create ad-hoc and/or ongoing smaller committee's to address particular DSRIP activities. Examples could include a committee to problem-solve around a project that is not being successful, or a committee to deep-dive into workforce issue. All committees would be required to formally report out at the monthly RPAC meetings.
Bi-directional Information Flow to Projects	Project Implementation Collaboratives	Project Implementation Collaboratives (PICs) will be developed by DY1Q1 that will develop, update, and guide the CNYCC's project implementation planning process overtime with an eye towards meeting state project requirements, implementation of best practice, and broad system transformation
Management, Oversight, and Expertise	"Kristen Mucitelli-Heath, Interim Executive Director	"Oversee development and implementation of strategies for performance measurement and reporting

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	Joe Reilly – Interim CIO Lauren Wetterhahn - Performance Reporting "	Select and implement Project Management and population health management Platforms Establish reporting structure for PPS-wide performance reporting and communication; ensure creation and availability of clinical quality and performance reporting trainings for organizations and individuals throughout the network; oversee development of training program."
Clinical Oversight and Quality/Performance Improvement	Medical Director CNYCC Staff - TBD (by 11/31/2015)	Responsible for working with Clinical Governance Committee to oversee project implementation as well as develop and implement the PPS' Quality/Performance Improvement Plan

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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		
All CNYCC Partner Organizations, Including Service Providers and CBOs	Advisory, operational, technical input	Provide input on impact of key CNYCC policies and decisions on partners. Implement internal changes in partner organizations needed to achieve DSRIP goals.
IT Staff Within Individual Provider Organizations	Reporting and IT system maintenance	Monitor, tech support, upgrade of IT and reporting systems.
Consumers/Community	Engaging with the projects and organization	Participate in community-based CNYCC activities
External Stakeholders		
DOH	Using performance data to identify progress toward milestones	Determine extent to which CNYCC has achieved its goals for payment purposes.
Public Agencies – Local, County, State, and Federal	Participating in the projects and promoting the organization	Participating in the projects and promoting the organization

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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.

CNYCC will initially rely on claims-driven partner/provider metrics available within the MAPP Performance Measurement Portal, while clinical data-driven metrics will be reported by individual partners/providers from their local EHRs. CNYCC will begin implementing a Decision Support System (DSS) in DY1 that will be used to: 1) manage funds flows; 2) facilitate budget planning; and 3) perform rules-based forecasting and modeling. Additionally, by DY3, CNYCC will establish a comprehensive Population Health Management (PHM) platform to consolidate standardized clinical and administrative data from all eligible partners in order to: 1) centralize reporting functions; 2) perform advanced population health analytics including clinical and financial risk stratification; 3) develop patient registries to track at-risk populations and; 4) coordinate care across the continuum. The integration of claims and clinical data will allow identification of intra-CNYCC performance variation and cost and quality performance improvement opportunities. A Project Management Platform will also be implemented in DY1, which will be used for partner management, project management, and performance management and reporting will interface with the DSS and PHM platforms to ensure that the CNYCC will be driven by consistent, objective and measureable data that will ensure the effective and appropriate utilization of resources by the collaborative. The continued use of these platforms after the conclusion of the program will ensure that outcomes continue to be monitored and coordinated care delivery will remain in place and that CNYCC is able to move toward a value-based payment system.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

CNYCC success is dependent on having a well-functioning Project Management Platform that interfaces with other key systems (e.g., Decision Support System, Salient platform, PHM platform, and MAPP) and yields credible data for reporting ("up" from partners to the CNYCC and "down" from the CNYCC to partners) and quality improvement purposes. Key measures of success will be meeting milestones and reporting requirements and Board assessment of performance in relation to goals established. Specifically, key indicators of interest are establishing the Project Management Platform, percent of partners that use the system within one DSRIP quarter of being on-boarded, and percent of partners that engage in quality improvement activities (i.e., using data to identify need for improvement, engaging in change process, testing change, and spreading change when valuable).

IPQR Module 6.9 - IA Monitoring

Instructions :

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Milestone 1: PPS should develop tasks to support this milestone, there are none submitted.

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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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	In Progress	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1A- Identify clinical professions (MD, PsyD/PhD, PA, NP, LCSW, RN, etc.) of membership of CNYCC Board of Directors	In Progress	1A- Identify clinical professions (MD, PsyD/PhD, PA, NP, LCSW, RN, etc.) of membership of CNYCC Board of Directors	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 1B- Conduct initial interviews with practitioners to garner feedback about preferences for future engagement, to solicit names of additional practitioners to interview, and to identify champions.	In Progress	1B- Conduct initial interviews with practitioners to garner feedback about preferences for future engagement, to solicit names of additional practitioners to interview, and to identify champions.	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 1C- Develop communication strategies by clinical professional group.	In Progress	1C- Develop communication strategies by clinical professional group.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1D- Identify and engage local chapters of professional organizations including medical societies.	In Progress	1D- Identify and engage local chapters of professional organizations including medical societies.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1E- Present CNYCC-wide, standard performance report to professional groups in	In Progress	1E- Present CNYCC-wide, standard performance report to professional groups in profession-specific webinars based on output from quarterly report; gather participant feedback to inform content and format of future	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
profession-specific webinars based on output from quarterly report; gather participant feedback to inform content and format of future performance reporting webinars.		performance reporting webinars					
Task 1F- Draft practitioner communication and engagement plan, with strategies segmented by professional group, based on feedback from interviews.	In Progress	1F- Draft practitioner communication and engagement plan, with strategies segmented by professional group, based on feedback from interviews.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	In Progress	Practitioner training / education plan.	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 2A- Based on information needs identified during initial interview phase, develop preliminary DSRIP presentations	In Progress	2A- Based on information needs identified during initial interview phase, develop preliminary DSRIP presentations	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2B- Based on content of and feedback from first CNYCC-wide standard performance report to professional groups, identify topics for practitioner training such as project-specific reporting needs, tools, and standards; education on new CNYCC-wide clinical protocols; and CNYCC-wide operations changes related to strategic plans and assessments.	In Progress	2B- Based on content of and feedback from first CNYCC-wide standard performance report to professional groups, identify topics for practitioner training such as project-specific reporting needs, tools, and standards; education on new CNYCC-wide clinical protocols; and CNYCC-wide operations changes related to strategic plans and assessments.	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2C- Identify resources for developing trainings, whether pre-existing, internal to CNYCC, or through an outside	In Progress	2C- Identify resources for developing trainings, whether pre-existing, internal to CNYCC, or through an outside	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2D- Finalize practitioner training/education plan.	In Progress	2D- Finalize practitioner training/education plan	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2E- Obtain approval for training and educational plan from Clinical Governance Committee and	In Progress	2E- Obtain approval for training and educational plan from Clinical Governance Committee and the Board of Directors	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
the Board of Directors							

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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.	

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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	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Risk 1: Currently, practitioner engagement in DSRIP in CNYCC is uneven with the greatest participation among those practitioners affiliated with or employed by one of the four founding hospitals. This was related to ease of access and that the hospitals were willing to free up time for their involvement.

Potential Impact: Strategies to engage practitioners who are part of smaller groups or who are community-based have been less successful to date than desired. These practitioners are key to the success of CNYCC projects but also have less time available for DSRIP activities.

Risk 2: Going forward, one of the largest risks to successful implementation will be failing to find a balance between the convenience of online communication and education platforms, and the more in-depth involvement possible through logistically complicated in-person meetings.

Potential Impact: If the CNYCC relies entirely on online or remote learning strategies then some partners may not be as engaged as they need to be or absorb the information that they need to participate effectively in CNYCC projects

Risk 3: Failing to identify the right people within organizations for engagement, namely the practitioner champions, will impede implementation of the projects and reaching goals. Up to this point, CNYCC communications have been typically funneled through an administrative contact at each organization that was then responsible for passing information along to the relevant person(s). However, CNYCC's engagement and information needs are rapidly outgrowing this approach.

Potential Impact: If the right people within organizations are not identified these partners may become less engaged.

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.)

"Other organizational workstreams (Clinical Integration, Population Health Management, Financial Sustainability, Cultural Competency and Health Literacy, IT Systems and Processes, Performance Reporting, and Funds Flow) will generate the content which must be successfully communicated to practitioners and should incorporate practitioner feedback whenever possible.

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Workforce and Governance - Workforce and Governance workstreams will present venues for practitioner leadership and engagement in decision-making. We expect robust practitioner participation on the Clinical Governance committee and the Workforce Workgroup, as well as through the PAC. The Clinical Governance Committee of the Board is involved in overseeing & monitoring clinical aspects of CNYCC's 11 projects and approving the practitioner training plan. The Workforce workgroup will assist in the assessment of the human resource impacts of health system transformation under DSRIP, changes that will most certainly impact clinicians. Any strategies to address theses impacts will require their input and buy-in. Front-line clinicians as well as clinical quality professionals will provide crucial input on project activities and project funding models to ensure that they drive the desired changes in our attributed population's clinical & service utilization outcome variables.

IT Systems and Processes – Continuous coordination with IT Systems and Processes workstream is particularly important because the characteristics of the CNYCC network, namely its large geographic size, relatively small portion of direct physician employment compared to other regions of the State, and uneven levels of engagement between employed and independent physicians makes true clinical integration, coordination of IT systems and processes, and successful population health management particularly challenging. Lack of familiarity with each other and with CNYCC and the resultant lack of trust related to the same network characteristics may make funds flow and performance reporting (as it relates to funds flow and the differential administrative burden upon large versus small organizations) challenging as well. "

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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
Oversight and Approval	CNYCC Board of Directors	Develop and approve practitioner engagement activities
Oversight, Management, and Recommendations to the Board	Clinical Governance and HIT Committees of the Board	Develop and approve practitioner engagement activities
Consumer Input and Guidance	Consumer Advocates (TBD)	Provide insight and guidance regarding consumer attitudes, perceptions, and care seeking behaviors
Partner Engagement	Regional Project Advisory Councils (RPACs)	The RPACs are the CNYCC Partners' link to the CNYCC staff and Board related to DSRIP activities. The RPACs provide regional forums for an interactive process for education, problem solving, project implementation, community and consumer education, and relationship building. The RPACs also respond to queries from the Executive Project Advisory Council (EPAC). The RPAC may also create ad-hoc and/or ongoing smaller committee's to address particular DSRIP activities. Examples could include a committee to problem-solve around a project that is not being successful, or a committee to deep-dive into workforce issue. All committees would be required to formally report out at the monthly RPAC meetings.
Partner Engagement, Oversight, and Board Conduit to Partners	Executive Project Advisory Council	The EPAC is the partners' link to the CNYCC BOD. This committee monitors all aspects of the DSRIP process from the Partner perspective. EPAC monitors project performance and quality indicators, considers changes, tracks workforce needs, Partner performance (via review of individual partner, project and regional score cards) and fund distribution. The EPAC responds to queries from the BOD and/or Board Committees as well as communicates to the BOD and/or Board Committees issues/concerns/suggestions from the RPAC's.
Bi-directional Information Flow to Projects	Project Implementation Collaboratives	Project Implementation Collabotatives (PICs) will be developed by DY1Q1 that will develop, update, and guide the CNYCC's project implementation planning process overtime with an eye towards meeting state project requirements, implementation of best

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		practice, and broad system transformation
Management, Oversight, and Expertise	"Kristen Mucitelli-Heath, Interim Executive Director Joe Reilly – Interim CIO Lauren Wetterhahn - Performance Reporting "	"Oversee development and implementation of strategies for practitioner engagement Administer trainings, analyze pre- and post-training materials, conduct and analyze period engagement surveys. Conduct initial interviews with non-physician practitioners, conduct follow-up interviews, administer trainings, analyze pre- and post-training materials, conduct and analyze period engagement surveys."

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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		
CNYCC Partner Organizations' Practitioner Workforce	Target audience for communication/engagement plan & training/education plan; source of on-the-ground experience to inform project implementation	Participate in interviews and other engagement opportunities, attend trainings and complete pre- and post-training evaluation materials.
Workforce Strategy Workgroup	Development and oversight of CNYCC-wide workforce strategy & DSRIP impacts	On-going assessment of CNYCC-wide workforce's training/educational needs.
Patients, Both uninsured, Medicaid members, and those with other sources of insurance	Represent patient concerns based on own experience of care	Receive care from practitioners in our CNYCC whose levels of engagement may vary.
External Stakeholders		
Local Chapters of State or National Professional Organizations	Represent concerns and interests of members	Audience for CNYCC communications and engagement activities.
Unions Representing Practitioners	Represent concerns and interests of members	Audience for CNYCC communications and engagement activities.

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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.

"CNYCC website and integrated discussion forums; email lists; webinar calendar, registration, and archives; and survey functions will be important to the success of the practitioner engagement strategy. Professional group-specific web pages with discussion forums, tailored content, identification of professional groups' representatives to the CNYCC Board of Directors and board committees, and professional group email list sign-up information will provide an online space for peer engagement and be a resource for relevant information.

Standard performance reporting and the success of the clinical integration elements of selected projects are heavily dependent upon the success and timely progress of the broader CNYCC HIT/HIE strategy and infrastructure. In the short term, rapid adoption and accurate use of the project management platform for reporting of Domain 1 project process metrics will be key. In the longer term, increased EHR interoperability, RHIO participation, and adoption of the CNYCC's population health management platform and its true integration into providers' day-to-day practices will be essential for attainment of our Domain 2, 3, and 4 measure goals."

IPQR Module 7.8 - Progress Reporting

Instructions :

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

CNYCC success is dependent on meeting milestones, including the development of plans for engagement, communication and education of practitioner partners. Plans for these practitioner communication, engagement, training, and education activities will need to be informed and refined overtime by feedback from participating partners and practitioners. These plans will also need to developed and refined based on changing conditions and DSRIP requirements. Key measures of success will be meeting milestones, reporting requirements, and speed and scale elements (i.e. patient activation and provider ramp-up). Key reporting indicators will include progress in engaging partners and practitioners in RPAC meetings, PIC meetings, project collaboratives, and other training activities. Additionally, CNYCC will conduct periodic engagement surveys of our CNYCC's practitioners and provide venues for more open-ended feedback, including at RPAC meetings and regular performance presentations to the professional groups. CNYCC and the current workforce vendor, AHEC, are in discussions regarding shared responsibility for tracking and reporting training requirements related to DSRIP, including those described above. AHEC intends to provide this resource across the PPSs where it has been contracted. This may facilitate progress reporting as it relates to CNYCC's practitioner training/education plan. CNYCC's close working relationship with AHEC also presents opportunities to incorporate tracking other aspects of practitioner engagement through their ongoing and CNYCC workforce-strategy specific activities.

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IPQR Module 7.9 - IA Monitoring

Instructions :

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Section 08 – Population Health Management

IPQR Module 8.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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	09/30/2016	09/30/2016	DY2 Q2	NO
Task 1. Conduct inventory of available data sets to supplement existing data from CNA, the MAPP tool, and other resources	In Progress	1. Conduct inventory of available data sets to supplement existing data from CNA, the MAPP tool, and other resources	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Identify data gaps and expand on the data collected as needed for program planning and care management	In Progress	2. Identify data gaps and expand on the data collected as needed for program planning and care management	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Develop overarching plan for achieving PCMH 2014 Level 3 certification in relevant provider organizations	In Progress	3. Develop overarching plan for achieving PCMH 2014 Level 3 certification in relevant provider organizations	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. Identify priority clinical areas drawn from CNA and other sources	In Progress	4. Identify priority clinical areas drawn from CNA and other sources	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Develop interim and long term data access/ aggregation strategy for all metrics associated	In Progress	5. Develop interim and long term data access/ aggregation strategy for all metrics associated with priority clinical areas	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
with priority clinical areas							
Task 6. Conduct current state PHM HIT assessment for CNYCC partners	In Progress	6. Conduct current state PHM HIT assessment for CNYCC partners	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7. Complete inventory of HIT-related PHM deliverables and current use cases for each of the DSRIP projects	In Progress	7. Complete inventory of HIT-related PHM deliverables and current use cases for each of the DSRIP projects	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 8. Identify needed functionality and select a PHM software vendor	In Progress	8. Identify needed functionality and select a PHM software vendor	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 9. Finalize population health management roadmap and receive approval of Board of Directors	In Progress	9. Finalize population health management roadmap and receive approval of Board of Directors	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
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.	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1. Establish baseline and develop process to monitor staffed bed volume	In Progress	1. Establish baseline and develop process to monitor staffed bed volume	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2. Establish methodology to determine impact of DSRIP on staffed bed volume	In Progress	2. Establish methodology to determine impact of DSRIP on staffed bed volume	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Develop partner bed reduction/service transformation plans on an as needed basis	In Progress	3. Develop partner bed reduction/service transformation plans on an as needed basis	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Task 4. Establish Board Sub-committee to be convened on an as needed basis to review and respond to bed reduction/service transformation plans	In Progress	4. Establish Board Sub-committee to be convened on an as needed basis to review and respond to bed reduction/service transformation plans	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Task 5. Finalize Bed Reduction/Service Transformation Plan(s) and receive approval of Board of Directors, as appropriate	In Progress	5. Finalize Bed Reduction/Service Transformation Plan(s) and receive approval of Board of Directors, as appropriate	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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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	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 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.

Risk1: Without a collaborative approach to the Community Needs Assessment (CNA), there could be a lack of consistency, consensus, and buy-in regarding strategic priorities and the identified approaches to addressing these priorities.

Potential Impact: There will be lack of commitment or buy-in towards a coordinated or collective response to community needs and priorities.

Risk 2: Given the overlapping nature of New York's health care markets and transportation patterns, the DSRIP CNYCC boundaries present a somewhat arbitrary way of segmenting the service area populations. For example, an individual could live in one CNYCC service area but seek services in a neighboring CNYCC service area. Collaboration across neighboring CNYCC' to explore how they can align their efforts to meet the needs of those throughout the broader Central New York and Upstate New York region is essential.

Potential Impact: Lack of commitment or buy-in towards a coordinated or collective response to community needs, priorities, and project plans will mean less effective and lower quality care.

Risk 3: Not all service providers utilize meaningful use certified EHRs, which will lead to further fragmentation of services and poor coordination

Potential Impact: PCMH Level 3 recognition as well as appropriate care planning, care coordination, health information exchange, and information flow between providers will not be possible unless eligible providers have meaningful use certified EHRs that are capable of facilitating the necessary care planning, care coordination, and information sharing.

Risk 4: CNYCC lacks a centralized data analytics and PHM platform.

Potential Impact: Success of CNYCC will rely on the ability of clinical and non-clinical practices/providers to identify those at-risk, share information, coordinate care, integrate service strategies, and monitor care, particularly of those most at-risk over time.

Risk 5: CNYCC must ensure that there is a strong data governance structure that will provide a framework in which pertinent clinical information can be aggregated and analyzed for partner and PPS performance. Data governance practices for each partner organization vary widely, and there is currently no systematic methodology for documenting and sharing the data that will be required to generate metrics of interest.

Potential Impact: Without a strong IT Data Governance structure in place, CNYCC will be unable to generate the necessary metrics for reporting requirements.

Risk 6: The care provided by participating practices could be uncoordinated and reactive rather than a data-driven, PHM approach that promotes integrated, well-coordinated care across partners.

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Potential Impact: Without a coordinated PHM approach, individual practices and providers could be providing guideline-driven, evidenced-based care to patients but that care could be provided in silos leading to an inefficient, uncoordinated, duplicative response overall.

IPQR Module 8.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

"The most significant dependencies with respect to other workstreams relate to:
IT Systems and Processes - All CNYCC projects are expected to need to leverage the base Population Health infrastructure. As such, it will be important to map the project requirements against the chosen Population Health Management system. Implementation of the system will similarly affect timelines for rollout of each project.
Clinical Integration - Clinical Integration is an essential component of population health management. Without full clinical integration, a population health vision and strategy cannot be obtained; this requires that stakeholders engaged in these two workstreams coordinate and collaborate in their efforts. "

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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
Oversight and Approval	CNYCC Board of Directors	Develop and approve population health management and bed reduction strategies as appropriate
Oversight, Approval, and Recommendations to the Board	Clinical Governance and HIT Committees of the Board	"Develop and approve population health management and bed reduction strategies as appropriate Oversee implementation of population health management platform "
CNYCC Board of Directors Sub-committee on Bed Reduction and Transformation Planning (as-needed)	TBD	Oversee and approve bed reduction and transformation planning plans across hospital partners
Consumer Input and Guidance	Consumer Advocates (TBD)	Provide insight and guidance regarding consumer attitudes, perceptions, and care seeking behaviors
Partner Engagement	Regional Project Advisory Councils (RPACs)	The RPACs are the CNYCC Partners' link to the CNYCC staff and Board related to DSRIP activities. The RPACs provide regional forums for an interactive process for education, problem solving, project implementation, community and consumer education, and relationship building. The RPACs also respond to queries from the Executive Project Advisory Council (EPAC). The RPAC may also create ad-hoc and/or ongoing smaller committee's to address particular DSRIP activities. Examples could include a committee to problem-solve around a project that is not being successful, or a committee to deep-dive into workforce issue. All committees would be required to formally report out at the monthly RPAC meetings.
Partner Engagement, Oversight, and Board Conduit to Partners	Executive Project Advisory Council	The EPAC is the partners' link to the CNYCC BOD. This committee monitors all aspects of the DSRIP process from the Partner perspective. EPAC monitors project performance and quality indicators, considers changes, tracks workforce needs, Partner performance (via review of individual partner, project and regional score cards) and fund distribution. The EPAC responds to queries from the BOD and/or Board Committees as well as

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		communicates to the BOD and/or Board Committees issues/concerns/suggestions from the RPAC's.
Bi-directional Information Flow to Projects	Project Implementation Collaboratives	Project Implementation Collabotatives (PICs) will be developed by DY1Q1 that will develop, update, and guide the CNYCC's project implementation planning process overtime with an eye towards meeting state project requirements, implementation of best practice, and broad system transformation
Management, Oversight, and Expertise	Project manager for population health management	Oversee development and implementation of population health management and bed reduction strategies as appropriate
PHM Platform Vendor	Key partner in implementing PHM platform	Technical assistance in implementing and maintaining platform

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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		
All CNYCC Partner Organizations, including service providers and CBOs	Advisory, operational, technical input	Provide input on impact of key CNYCC policies and decisions on partners. Implement internal changes in partner organizations needed to achieve DSRIP goals.
Consumers/Community	Engaging with the projects and organization	Participate in community-based CNYCC activities
CNYCC Hospital Partners who will participate in Bed Reduction and Transformation Planning Sub-committee	Stakeholder in Bed Reduction and Transformation Planning	Represented on the Bed Reduction and Transformation Planning Sub-group; Will sign off on any Bed Reduction/Transformation Plans
External Stakeholders		
MCOs	Key partner in payment reform	Collaborate in PPS payment reforms (VBP) in line with VBP roadmap; provide insight into population health management approach to be implemented across Forestland PPS

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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.

"1) Core Application Systems: CNYCC will establish a core application system enablement program focused on the penetration and effective utilization of the technologies required to capture and consolidate the data needed to successfully implement PHM strategies. Most notably is the acquisition and implementation of a dedicated PHM platform. This net new community investment will enable collaborative care planning across the continuum, including real-time access to pertinent clinical information to facilitate safe transitions of care, as well as maintaining a shared, multidisciplinary care plan that will be accessible to all members of a patient's care team. The PHM platform will also enable analytics for prospective and predictive modeling to support clinical, fiscal, and operational decisions and ensure that high risk and high utilizing patients can be proactively managed. This will also allow for monitoring and measuring the effectiveness of the projects implemented by the DSRIP, providing a critical feedback mechanism to the collaborative. Registry functionality available through the PHM platform will enable tracking target populations, including performance on the quality and outcome measures defined by the DSRIP initiatives, as well as other indicators that are deemed appropriate as program development evolves. Finally, the PHM platform will enable roles, and rules-based reporting, facilitating access to actionable data for CNYCC partners.

2) Interoperability, Connectivity and Security: The current HIT infrastructure of CNYCC is characterized by a well-established HIE via the HealtheConnections RHIO. Securely connecting stakeholders to allow access to consolidated patient data and enable information sharing will be accomplished through the RHIO. Functions provided by the RHIO include creating standard patient identification, transforming and standardizing data from multiple points of origin, "pushing" summary data to connected physicians, managing the exchange of unstructured data (i.e. Images/RAD), and providing alerts to CNYCC providers. Information is currently shared with the RHIO by all of CNYCC's hospitals, some of the ambulatory providers, and a majority of the diagnostic centers (lab and radiology) in the region. Access to this information is facilitated through a web-based portal that is available to any provider with appropriate consent, as well as through results delivery. As part of this project, CNYCC and the RHIO will collaborate to establish additional bi-direction, real-time, and near real-time data transmission from and to all eligible providers.

3) Engagement Technologies: Data consolidated in the RHIO will be available to eligible providers through the existing web-based portal. In addition, the selected PHM solution will provide role-based access to consolidated data for all providers across the continuum of care. The PHM solution will also facilitate engagement across all areas of the care continuum and assist in managing outreach to target populations.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

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CNYCC success is dependent on meeting milestones including developing a population health roadmap and finalizing a plan for dealing with bed reductions. Key measures of success will be meeting milestones and reporting requirements as well as Board assessment of performance in relation to established goals. Key reporting indicators of interest will include progress in developing these plans. Additionally, CNYCC will report on progress in conducting regular needs assessments, the results of which inform strategic planning and population health strategies.

IPQR Module 8.9 - IA Monitoring

Instructions :

Milestones #1 and 2 do not have any tasks. These need to be developed and submitted.

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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	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	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1A- Map network partners' clinical integration needs by partner type and by project	In Progress	1A- Map network partners' clinical integration needs by partner type and by project	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 1B- Assess key data points for shared access and key interfaces common across projects, identifying gaps where other	In Progress	1B- Assess key data points for shared access and key interfaces common across projects, identifying gaps where other	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 1C- Conduct needs assessment for clinical integration	In Progress	1C- Conduct needs assessment for clinical integration	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1D- Share draft needs assessment with key audiences & collect feedback	In Progress	1D- Share draft needs assessment with key audiences & collect feedback	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 1E- Finalize needs assessment based on feedback and present to the Clinical Governance Committee for review.	In Progress	1E- Finalize needs assessment based on feedback and present to the Clinical Governance Committee for review.	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee,	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		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					
Task 1. Based on results of the needs assessment, develop clinical integration strategy that includes clinical and other information for sharing, data sharing systems and interoperability, care transitions strategy, and training plan; timeline for implementation; and identification of responsible parties	In Progress	1. Based on results of the needs assessment, develop clinical integration strategy that includes clinical and other information for sharing, data sharing systems and interoperability, care transitions strategy, and training plan; timeline for implementation; and identification of responsible parties	04/01/2015	07/31/2016	09/30/2016	DY2 Q2	
Task 2. Share strategy with key audiences & gather feedback	In Progress	2. Share strategy with key audiences & gather feedback	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 3. Finalize clinical integration strategy based on feedback and present to the Clinical Governance Committee and the Board of Directors for approval	In Progress	3. Finalize clinical integration strategy based on feedback and present to the Clinical Governance Committee and the Board of Directors for approval	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform a clinical integration 'needs assessment'.	
Develop a Clinical Integration strategy.	

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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	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 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.

CNYCC has identified four major risks as outlined below. These risks are not unique to clinical integration. They are risks inherent in systems transformation more broadly. Risk mitigation strategies for clinical integration are part of the risk mitigation strategies to be employed overall by CNYCC.
Risk 1: As CNYCC moves toward transforming its health delivery system to a population health vision, it is essential to transform the system based on how it can best serve patients through providing the highest quality care at the right time and in the right setting for the patient. There is a risk, however, that the system does not develop in a way that supports person-centeredness.

Potential Impact: Not developing a system that is person-centered would mean falling short of a full population health approach. A critical component of person-centeredness is understanding the social determinants of health, such as poverty, culture, race/ethnicity, educational attainment, and housing status.

Risk 2: The shift toward a population health focus will take time.

Potential Impact: Without achieving a shared population health vision, CNYCC will not be able to fully reform its service system to be sustainable post-DSRIP.

Risk 3: Full clinical integration can only be achieved with the leadership and buy-in of the practitioner community. Clinical integration depends on practitioners working across disciplines and organizations on behalf of their patients.

Potential Impact: Without practitioner leadership to promote practitioner buy-in to clinical integration across the CNYCC, full clinical integration will not be achieved, which ultimately will compromise the capacity of CNYCC to achieve its goals.

Risk 4: Although organizational workstreams and projects are reported on separately for the Implementation Plan, CNYCC is acutely aware that they are all interrelated. Coordination across other organization workstreams and projects is essential.

Mitigation: The Clinical Governance Committee, reporting to and advising the Board of Directors, will have members knowledgeable of all other organizational workstreams and all 11 projects. Part of their role will be to oversee the coordination of clinical integration with these other workstreams and projects.

IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

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Instructions :

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

"Clinical integration will have interdependencies with all workstreams and all projects. However, the most critical workstreams are IT systems and processes, practitioner engagement, cultural competency/health literacy, funds flow, and population health management.

IT Systems and Processes - A first dependency is with IT Systems and Processes, especially as relates to clinical data sharing and interoperable systems across the CNYCC network. This will be facilitated by the RHIO and the Population Health Management (PHM) Platform to be established by the CNYCC. The clinical integration strategic plan will be shared with the IT Data Governance Committee to ensure that the PHM platform accommodates clinical integration needs. The Clinical Governance Committee and the IT Data Governance Committee will work closely throughout the DSRIP project.

Practitioner Engagement - Engaging practitioners in understanding and championing population health is part of the clinical integration strategy. Enabling the Clinical Governance Committee members to work with those involved with the practitioner engagement workstream will ensure coordination between these two areas. In addition, RPACs may also serve as a practitioner engagement strategy and a forum for discussion of clinical integration.

Cultural Competency/Health Literacy - As noted, understanding and addressing social determinants is critical for clinical integration. A social determinants approach in the work of the CNYCC, including the clinical integration work, is essential to achieving patient centeredness and population health goals. Social determinants also form the basis for the CC/HL strategy. Drawing on the CC/HL strategies will be essential for the clinical integration work.

Funds Flow - Funds flow strategies must incentivize clinical integration. Those working in the clinical integration workstream must have input into the Finance Committee to ensure these incentives.

Population Health Management - Clinical integration is an essential component of population health. Without full clinical integration, a population health vision and strategy cannot be obtained; thus, these requiring that stakeholders engaged in these two workstreams coordinate and collaborate in their efforts.
"

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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
Oversight and Approval	CNYCC Board of Directors	Develop and approve Clinical Integration strategy
Oversight, Approval, and Recommendations to the Board	Clinical Governance and HIT Committees of the Board	Develop and approve Clinical Integration strategy
CNYCC Board of Directors Sub-committee on Bed Reduction and Transformation Planning (as-needed)	TBD	Oversee and approve bed reduction and transformation planning plans across hospital partners
Consumer Input and Guidance	Consumer Advocates (TBD)	Provide insight and guidance regarding consumer attitudes, perceptions, and care seeking behaviors
Partner Engagement	Regional Project Advisory Councils (RPACs)	The RPACs are the CNYCC Partners' link to the CNYCC staff and Board related to DSRIP activities. The RPACs provide regional forums for an interactive process for education, problem solving, project implementation, community and consumer education, and relationship building. The RPACs also respond to queries from the Executive Project Advisory Council (EPAC). The RPAC may also create ad-hoc and/or ongoing smaller committee's to address particular DSRIP activities. Examples could include a committee to problem-solve around a project that is not being successful, or a committee to deep-dive into workforce issue. All committees would be required to formally report out at the monthly RPAC meetings.
Partner Engagement, Oversight, and Board Conduit to Partners	Executive Project Advisory Council	The EPAC is the partners' link to the CNYCC BOD. This committee monitors all aspects of the DSRIP process from the Partner perspective. EPAC monitors project performance and quality indicators, considers changes, tracks workforce needs, Partner performance (via review of individual partner, project and regional score cards) and fund distribution. The EPAC responds to queries from the BOD and/or Board Committees as well as communicates to the BOD and/or Board Committees issues/concerns/suggestions from the RPAC's.
Bi-directional Information Flow to Projects	Project Implementation Collaboratives	Project Implementation Collabotatives (PICs) will be developed by DY1Q1 that will develop, update, and guide the CNYCC's project implementation planning process overtime with an eye towards

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		meeting state project requirements, implementation of best practice, and broad system transformation
Management, Oversight, and Expertise	Project manager for population health management	Oversee development and implementation of population health management and bed reduction strategies as appropriate
Oversee Clinical Integration Workstream Activities/Workplan	Clinical Governance Committee	Assign CNYCC staff to oversee development of clinical integration needs assessment and strategic plan; appoint workgroup to fulfill activities; coordinate with IT systems and processes, practitioner engagement, CC/HL, funds flow, and population health workstreams.
HIT/HIE Functionality in Relation to Clinical Integration	IT Data Governance Committee CNYCC HIT/HIE staff	Ensure Population Health Management Platform addresses needs of clinical integration workstream
Monitor and Support of Clinical Integration Strategies	IT Data Governance Committee, CNYCC Project Management Staff, RPACs	Leverage strengths and address weaknesses in clinical integration at regional level; generate buy-in among providers to clinical integration strategic 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		
All CNYCC Partner Organizations, including service providers and CBOs	Advisory, operational, technical input	Provide input on impact of key CNYCC policies and decisions on partners. Implement internal changes in partner organizations needed to achieve DSRIP goals.
Consumers/Community	Engaging with the projects and organization	Participate in community-based CNYCC activities
CNYCC Partner Contacts and Subject Matter Experts Participating in Clinical Integration Activities	Participation in planning and implementation activities	Participation in planning and implementation activities
Practitioners	Practitioner's buy-in is essential to the success of this workstream	Engage with and remain current on activities of the CNYCC with regard to Clinical Integration, including through the website, participating in RPACs, and participating in any trainings in this area
External Stakeholders		
Consumers/Family Members/Caregivers/Community	Receiving improved care and health outcomes due to better clinical integration`	Improved health status; high satisfaction with care
CBOs	Provide services related to social determinants of health, which are essential for achieving full clinical integration on behalf of patients	Work with clinical providers to fulfill non-clinical needs of patients

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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.

Clinical integration will be dependent upon access to, and exchange of, pertinent clinical and administrative information among collaborating CNYCC partners. The current HIT infrastructure of the CNYCC is characterized by a well-established HIE via the HealtheConnections RHIO. Securely connecting stakeholders to allow access to consolidated patient data and enabling information sharing will be accomplished through the RHIO. Functions provided by the RHIO include creating standard patient identification, transforming and standardizing data from multiple points of origin, "pushing" summary data to connected practitioners, managing the exchange of unstructured data (i.e. images/RAD), and providing alerts to CNYCC providers. Currently all of the CNYCC hospitals, some ambulatory providers, and a majority of diagnostic centers (lab and radiology) in the region are sharing information with the RHIO. Access to this information is facilitated through a web-based portal that is available to any provider with appropriate consent, as well as through results delivery. As part of this project, CNYCC and the RHIO will collaborate to establish additional bi-direction, real-time, and near real-time data transmission from and to all eligible providers. Point-to-point communications to facilitate transitions of care are currently accomplished through the use of direct protocols, a HIPAA compliant mode of exchange adopted by EHR vendors as part of Meaningful Use (MU) stage 2. This real time mode of exchange is widely available across the CNYCC region, with 71% of eligible providers on the SureScripts network compared to 21% for the rest of the state. Web-based, secure messaging portals that support Direct will be made available to partners without EHRs, or whose current EHRs are not MU certified to facilitate the secure exchange of information among all applicable CNYCC partner organizations.
CNYCC will also establish a core application system enablement program focused on the penetration and effective utilization of the technologies required to capture and consolidate the data needed to successfully implement clinical integration strategies. Most notably is the acquiring and implementing a dedicated population health management platform. This net new community investment will enable collaborative care planning across the continuum, including real-time access to pertinent clinical information to facilitate safe transitions of care, and to maintain a shared, multidisciplinary care plan that will be accessible to all members of a patient's care team. The PHM platform will also enable analytics for prospective and predictive modeling to support clinical, fiscal, and operational decisions and ensure that high risk and high utilizing patients can be proactively managed. This will also allow monitoring and measuring the effectiveness of the projects implemented by the DSRIP initiative, providing a critical feedback mechanism to the collaborative. Registry functionality available through the PHM platform will enable tracking target populations, including their performance on the quality and outcome measures defined by the DSRIP initiatives, as well as other indicators that are deemed appropriate as clinical program development evolves.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

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CNYCC success is dependent on meeting milestones, including conducting a clinical integration needs assessment and developing a strategy specifically for clinical integration. The CNYCC will report on progress in achieving these milestones by tracking required outcome/process measures as well as by tracking the CNYCC's efforts to meet the steps detailed in the organizational plan. Critical to the CNYCC's success in this area will be working with the CNYCC Project Implementation Collaboratives (PICs) to explore opportunities for integration and synergies across projects that can be achieved through clinical integration. Once identified, these opportunities will be incorporated into the Clinical Integration Strategy along with clear measures to track progress. These measures will be tracked overtime and reported to the RPACs/EPAC, Clinical Governance Committee, the Board of Directors, and to the DOH through the quarterly reports. In addition, Domain 2 and 3 metrics will be tracked as part of regular CNYCC/DSRIP activities and will allow the CNYCC to track and report indirectly on clinical integration progress to the extent that project success will depend on appropriate integration of services across settings and projects.

IPQR Module 9.9 - IA Monitoring:

Instructions :

Milestone #2 does not have any tasks. These need to be developed and submitted.

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Central New York Care Collaborative, Inc. (PPS ID:8)

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.

CNYCC's approach to implementation is rooted in six core functions: Strategic engagement and education; Building upon partner strengths; Transparency and communication; and Accounting for regional differences.

Strategic engagement and education: Execution of the Project Implementation Plan will require a strategic approach to partner engagement. To this end, CNYCC will develop a partner "onboarding" process. The process will include an organizational readiness assessment to categorize partner ability to reach patient and implementation speed goals set forth in the Project Plan Application as well as to identify the training and technical assistance needed to address gaps in partner capacity. More specifically the onboarding assessment approach will assess partner and CNYCC readiness to participate in projects and to meet speed and scale obligations; identify complexities to participation that can potentially be mitigated by the CNYCC; capture vital information that will inform the onboarding process and ongoing work, and; further promote partner engagement, bi-directional information flow, and relationship building.

Building on strengths: Based upon the assessment, CNYCC will develop a strategic "onboarding" process to engage partners that are innovators and early adopters as well as establish capacity building strategies for moderate adopters and lagging adopters. The assessment process will also provide an opportunity to identify areas for TA/support that can be provided directly by peer organizations or through experts. While many inputs will be necessary to fully define partner contracts, the onboarding assessment will assist in articulating the specific partner obligations, resources (such as TA/support), reporting requirements and the areas of partner expertise that may be leveraged to develop peer support structures within the implementation process.

Transparency and communication: CNYCC will develop a portal on its website to catalog and make available information on implementation science and best practices both focused on overall clinical and delivery system change as well as project specific support materials. The existing CNYCC website provides a venue for sharing information, archiving recorded webinars and implementation plans, and fostering open dialog between PPS partners. The current approaches with which CNYCC has been engaged will be further utilized to this end. These have included conducting webinars, pushing information and notices out to the CNYCC listserv and the CNYCC newsletter. Regional Project Advisory Committees (RPACs, described below) will provide another opportunity to promote transparency and communication.

Accounting for regional differences: The RPACs are the Network Partner link to CNYCC and DSRIP activities. They provide forums for an interactive process for education, problem solving, local focus and project implementation and ongoing success, community and consumer education on services, and relationship building. The RPAC may also create ad-hoc and/or ongoing smaller committees to address particular DSRIP activities, address challenges or leverage partner expertise for the betterment of the entire partner network. Examples could include a committee to problem-solve around a project that is not being successful, or a committee to conduct deep-dive into workforce issue. All committees would be required to formally report out at the monthly RPAC meetings.

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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.

Implementing and managing the eleven CNYCC projects is complex as the number of requirements, associated tasks and dependencies are abundant. In particular, there are several work streams that require coordination and ongoing monitoring to assure resources and staffing are distributed appropriately and are flexible enough to respond to changing needs, unforeseen challenges, and partner workload. These include: 1) Developing an HIT infrastructure that is responsive to the needs and timing of each project, including overarching projects such as 2ai. Alerts, messaging, population health management, reporting and PCMH requirements will require a strategic roll out of the HIT strategy. To this end CNYCC has contracted with Chartis to develop a strategic roadmap and guidance to meet these requirements. 2) Workforce approaches, particularly those focused on training and recruitment, require understanding the need for new staff and the amount of time for recruitment. Many projects require adding staff, particularly in mental health, care management, and primary care staff. Given the high demand and scarcity of these health professionals CNYCC will need to anticipate workforce needs and partners will need to begin the recruitment process well in advance of project staffing needs. Additionally, a timed roll out of training strategies to minimize impact on staff time will be coordinated. To this end CNYCC has contracted with NAHEC to develop a strategic roadmap to meet workforce needs. 3) Quality improvement and rapid cycle improvement strategies will drive the success of the CNYCC's efforts. DSRIP is predicated on the use of process and performance metrics that will be used to monitor progress, guide performance improvement efforts, and hold the CNCYCC and its partners accountable. As will be discussed in greater detail elsewhere, CNYCC is establishing a robust HIT infrastructure and performance management system that will be utilized to drive quality improvement efforts. CNYCC will track and monitor performance at the project- and partner-level. These will be based in large part on reporting requirements established by the DOH. In addition, the CNYCC will provide specialized training and technical assistance to instill a cultural of quality among its partners that will ultimately help to ensure that the highest quality care is provided, in a culturally appropriate, person-centered manner. 4) The CNYCC governance and staffing structure has been defined to coordinate the development and approval of clinical and operational protocols and guidelines. While the centralized approach will assure coordination of activities and content, final operating and clinical guidelines will be vetted with CNYCC partners before submission to the Board for approval. CNYCC will utilize Performance Logic's DSRIP Tracker as its project management platform to provide adequate oversight of project activities, track dependencies, manage project resources, and maintain agility in correcting project trajectories or mitigating unexpected events. DSRIP Tracker will assist the management team in adjusting the implementation approach to avoid extreme peaks and troughs of activities that may prove overly burdensome for the CNYCC management team or for partners engaging in multiple projects. In instances where peaks of activities cannot be mitigated by adjusting the implementation approach, utilization of DSRIP Tracker allows for the early identification and mobilization of additional resources (staff, consultants and vendors) in order to minimize the disruptive impact on CNYCC and the partner organizations. Furthermore, CNYCC is exploring the extent to which DSRIP Tracker can assist in cost controls, budget management, resource allocation, quality management and documentation/verification of implementation activities.

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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
Workforce	Northern and Central Area Health Education Center Program/Anita Merril	Assist in the developing and implementing a comprehensive workforce development plan.
HIT Planning, population health management vendor selection, and PMO organization support	Aspen Advisors/Tim Weldon, Craig Dolezal, Dasha Adamchik, Vince D'Itri, Elaina Sendo,	Assist in the developing and implementing an HIT and HIE strategy, selection process for a Population Health Management platform, and establishing CNYCC's PMO's protocols and processes.
PCMH planning support	HANYS Solutions PCMH Advisory Services/Nicole Harmon & Jill Barone	Assist in the developing and implementing a PCMH strategy
Engagement and Education	Eric Mower + Associates	Assist in the developing and implementing an engagement and education approach.
Project Management	Lauren Wetterhahn (Director of CNYCC's PMO), Michele Treinin (Project Manager for Data & Performance), Kelly Lane (Project Manager), more staff TBD. For HIT deliverables: Joe Reilly (CNYCC's Interim CIO) and staff TBD.	CNYCC staff will be responsible for project management and the mobilization of resources to assure timely and effective implementation. Staff provide a link between the Board of Directors and DSRIP projects as well as have primary responsibility for reporting and communication with NYDOH Oversight of the clinical quality committees for individual projects Day-to-Day management of progress against Project requirements

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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		
Clinical Governance Committee	Clinical and quality oversight	Oversees development of evidence-based, standardized protocols, metrics, and clinical performance goals for projects across the system
Compliance Committee	Compliance oversight	Oversees CNYCC compliance program and conduct in terms of adherence to DSRIP requirements and laws, and regulations applicable to PPS activities and operations, including health care privacy.
Finance Committee	Financial oversight	Oversees CNYCC and project budgets, reporting and financial performance; reviews project expenditures and assists in financial analysis for value based reimbursement
IT/Data Governance Committee	HIT strategy implementation oversight	Oversees activities and vendors to create, implement, and use HIT/HIE infrastructure
Executive Project Advisory Committee	Engagement and performance	Works with Regional Project Advisory Committees to engage stakeholders. Oversees project performance and advises the Board of developments & concerns.
Regional Patient Advisory Committees	Engagement, Education, Implementation	Advises the EPAC to assure patient perspectives inform projects and patient engagement strategies.
Consumer Input and Guidance	Consumer Advocates (TBD)	Provide insight and guidance regarding consumer attitudes, perceptions, and care seeking behaviors
Bi-directional Information Flow to Projects	Project Implementation Collaboratives	Project Implementation Collabotatives (PICs) will be developed by DY1Q1 that will develop, update, and guide the CNYCC's project implementation planning process overtime with an eye towards meeting state project requirements, implementation of best practice, and broad system transformation
Bi-directional Information Flow to Projects	Project Implementation Collaboratives	Project Implementation Collabotatives (PICs) will be developed by DY1Q1 that will develop, update, and guide the CNYCC's project implementation planning process overtime with an eye towards meeting state project requirements, implementation of best practice, and broad system transformation

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Regional Project Advisory Committees	Performance and Engagement	RPACs will be a critical element of the project performance monitoring process and will provide input on regional variations impacting project implementation. They will also provide a forum for consumer and community engagement.
External Stakeholders		
Northern and Central Area Health Education Center Program	Workforce	We have engaged AHEC to assist in the development and implementation of a comprehensive workforce development plan.
Prevention Coalitions/PHIP	Project Implementation Support	PHIP will assist in engaging county prevention coalitions related to Domain 4 projects.
Labor Unions	Workforce	Assist in workforce planning activities.
Regional and County Mental Health, Public Health, Alcohol and Substance Abuse Services Agencies	Project Implementation Support	State and county agencies are participating in CNYCC Regional Project Advisory Council meetings to inform and facilitate integration across PPS partners
HealtheConnections	Qualified Entity/RHIO/Health Information Exchange	HealtheConnections is the Regional Health Information Organization with which will assist CNYCC in developing an integrated system through information sharing strategies.

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IPQR Module 10.5 - 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.

Risk 1: Lack of coordination for clinical and health related services across the continuum of health are a barrier to achieving PPS goals. While clinical and operational protocols adhering to evidence based practices will be developed there is a possibility that parallel pathways among individual projects may overlap, creating duplication and inefficiencies in the provision of care. Impact: Overlap and duplication of effort has the potential to confuse both partners and patients and interrupt continuity of care, which would be counterproductive to attaining DSRIP goals. Mitigation: In order to create vertical and horizontal system-ness, the Clinical Governance Committee will be responsible for overseeing PPS care delivery, care coordination, quality standards and project quality improvement including, developing standardized processes, evidence-based pathways, and a rapid cycle improvement processes. The Committee will be responsible for overseeing adoption of clinical and operational guidelines for each project system-wide as well as identifying common guideline elements that will be consolidated to reduce duplication and overlap. Risk 2: The culture of provider based care is very strong and if unchecked will be counter-productive to DSRIP goals. Impact: Many partners find collaboration difficult and have built their own capacity rather than collaborate. In this cultural environment partners, such as primary care practices, are expected to do more and provide a scope of services for which they do not have capacity or resources to accomplish effectively. The result is an overextension of partner resources and an incomplete approach to patient care. Mitigation: Regional multispecialty and multiservice integrated delivery systems exist, albeit siloed based on organizational structure, geography or organizational alliances. These integrated systems can serve as foundational components of a region-wide IDS. These partners can lead local efforts, collaborate with their regional counterparts and lead IDS development using their experience and existing systems as a platform on which to build. Risk 3: Negotiation with MCOs by individual providers and local systems can result in disparate contracting arrangements and create a fragmented approach to care. Impact: Smaller partners do not have the capacity to conduct the cost benefit analysis to demonstrate effectiveness and successfully participate in MCO arrangements. Similarly, smaller organizations may not have sufficient numbers of patients to participate in Medicaid managed care. This may result in varying MCO contract parameters for care coordination and quality. Partners will be able to contract with MCOs independent of CNYCC if they choose to do so. Mitigation: CNYCC will provide a centralized function of conducting cost benefit analysis of activities and entering into negotiations with MCOs. This will enable partners to participate in MCO contracting regardless of the size of their patient population. Risk 4: CNYCC's negotiations with MCOs will require collection of adequate cost benefit data across partners. Impact: Thorough collection of data and collective negotiation with MCOs in a manner that is open and transparent with all PPS partners takes significant time and will delay the ability of partners to complete milestones related to negotiating value based payments with MCOs. Compensating for this by adjusting the Milestone Implementation Speed may reduce the volume of payments in DY3 and increase the volume in DY4. Mitigation: CNYCC has adjusted its Milestone Implementation Speed to compensate for the timing. The Finance Committee will develop a budgeting process to accommodate fluctuations in payments and CNYCC has already engaged MCOs in identifying pilot projects to facilitate future negotiations, including identifying data to build the business case for contracts.

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IPQR Module 2.a.i.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY4,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	307	0	0	0	0	0	0	0	0	0	0
Non-PCP Practitioners	973	0	0	0	0	0	0	0	0	0	0
Hospitals	17	0	0	0	0	0	0	0	0	0	0
Clinics	56	0	0	0	0	0	0	0	0	0	0
Health Home / Care Management	16	0	0	0	0	0	0	0	0	0	0
Behavioral Health	106	0	0	0	0	0	0	0	0	0	0
Substance Abuse	18	0	0	0	0	0	0	0	0	0	0
Skilled Nursing Facilities / Nursing Homes	37	0	0	0	0	0	0	0	0	0	0
Pharmacies	7	0	0	0	0	0	0	0	0	0	0
Hospice	4	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	29	0	0	0	0	0	0	0	0	0	0
All Other	723	0	0	0	0	0	0	0	0	0	0
Total Committed Providers	**2,293**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	307	0	61	122	183	244	307	307	307	307	307
Non-PCP Practitioners	973	0	195	390	585	780	973	973	973	973	973

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Hospitals	17	0	3	7	10	14	17	17	17	17	17
Clinics	56	0	11	22	33	44	56	56	56	56	56
Health Home / Care Management	16	0	3	6	9	12	16	16	16	16	16
Behavioral Health	106	0	21	42	63	84	106	106	106	106	106
Substance Abuse	18	0	3	7	10	14	18	18	18	18	18
Skilled Nursing Facilities / Nursing Homes	37	0	7	14	21	28	37	37	37	37	37
Pharmacies	7	0	1	3	4	6	7	7	7	7	7
Hospice	4	0	0	1	2	3	4	4	4	4	4
Community Based Organizations	29	0	6	12	18	24	29	29	29	29	29
All Other	723	0	145	290	435	580	723	723	723	723	723
Total Committed Providers	**2,293**	**0**	**456**	**916**	**1,373**	**1,833**	**2,293**	**2,293**	**2,293**	**2,293**	**2,293**
Percent Committed Providers(%)		**0.00**	**19.89**	**39.95**	**59.88**	**79.94**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

LW entered on 08/06/15 "Project requirement 's first metric/deliverable, "Primary care capacity increases improved access for patients seeking services - particularly in high-need areas" which is documented by "Status reporting of recruitment of PCPs, particularly in high-need areas; Demonstration of improved access via CAHPS measurement" will require most of the project's implementation time frame to achieve. Since that requirement is assigned to the project unit level, no individual providers can meet all of the project requirements (as set out in the project Plan Application) until that date. We believe this project requirement represents the "rate limiting" requirement for Project 2ai because the significant lag time required for CNYCC partner organizations to recruit, let alone generate the necessary budget for, additional primary care staff. Additionally, in order to demonstrate that this metric/deliverable has been met, CAHPS measures must illustrate this improved primary care access, requiring adequate and representative outcome data to be collected which will occur late in the DSRIP period.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	In Progress	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.	Project		In Progress	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 1a. Disseminate information and materials via professional membership organizations including websites and newsletters a minimum of annually	Project		In Progress	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1b. Present information regarding PPS activities at professional membership annual meetings	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1c. Meet with individual providers or organization representatives as requested	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1d. Conduct annual review of project progress and IDS composition to identify key partner shortfalls necessary to accomplish goals	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1e. Assess service gaps and explore contracting options or, when available, partner additions	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1f. Develop partner contract, MOU and other agreement templates.	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1g. Identify partner-specific obligations including adoption of common system-wide clinical or operational protocols, and required reporting processes.	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1h. Disseminate, negotiate and execute partner contracts, MOUs or agreements.	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2A. Conduct gap analysis of HHs, ACOs and PPS system integration.	Project		In Progress	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2b. Develop organization-specific plans to incorporate HHs and ACOs into IDS	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2c. Include HHs and ACOs in HIT/HIE assessment (see tasks below)	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 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	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	04/01/2015	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	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS trains staff on IDS protocols and processes.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4a. HIT/HIE strategy incorporates tracking processes	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Related HIT IP Milestone: Develop roadmap to achieving secure clinical data sharing and interoperable systems across PPS network.	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2a. Develop and present data sharing roadmap components to IT and Data Governance Board subcommittee including: HIE and data sharing current state	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
assessment; data sharing rules and enforcement strategy; proposed technical standards for a common clinical data set; proposed training plan							
Task 2b. Obtain board approval for data sharing roadmap	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
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.	Project	N/A	In Progress	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 Primary Care Physicians	In Progress	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 Non-PCP Practitioners	In Progress	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 Hospitals	In Progress	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 Behavioral Health	In Progress	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 Skilled Nursing Facilities / Nursing Homes	In Progress	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	03/31/2018	DY3 Q4
Task a. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task b. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task c. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task d. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Obtain board approval for data sharing rollout plan	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #5	Project	N/A	In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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).	Project		In Progress	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	Safety Net Primary Care Physicians	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1a. Work with providers and vendors to align requirements with implementation strategies	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1b. Develop plans to help community providers assess and provide EHR solutions	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2a. Identify all participating safety net primary care practices and associated providers	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2b. Establish HIT/HIE and Primary Care Transformation workgroups.	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2c1 Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements	Project		In Progress	08/04/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2c2 Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.	Project		In Progress	08/04/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2d Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.	Project		In Progress	08/04/2015	01/31/2016	03/31/2016	DY1 Q4
Task 2e Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 2f Conduct baseline assessments of providers/practices' MU Stage 2 and	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PCMH 2014 statuses.							
Task 2g Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 2h Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.	Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2i Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.	Project		In Progress	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 2j PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 2k Participating providers successfully complete MU Stage 2 attestation.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
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	03/31/2019	03/31/2019	DY4 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 1. Convene with project participants/providers to inventory registries that would be useful for the identification, stratification, and engagement of patients for the	Project		In Progress	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
project							
Task 2. Work with project participants to define and inventory additional data required to facilitate care coordination among participating partners.	Project		In Progress	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Finalize registry requirements, including inclusion/exclusion criteria and metric definitions.	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6. Identify core data elements needed for registry/metric requirements as well as care coordination data and identify the expected sources of data.	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7. Complete gap analysis to compare required data to currently available data.	Project		In Progress	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 8. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Work with participating partners and their EMR vendors to identify local registry capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Finalize required functionality and select a PHM software vendor	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 12. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning)	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 13. Implement PHM roadmap	Project		In Progress	04/01/2015	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	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Provider	Primary Care Physicians	In Progress	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	03/31/2018	DY3 Q4
Task 6a. Work with providers and vendors to align requirements with implementation strategies	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 6b. Develop plans to help community providers assess and provide EHR solutions	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Related Workforce Milestone: Define target workforce state (in line with DSRIP program's goals)	Project		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Related Workforce Milestone: Create a workforce transition roadmap for achieving your defined target workforce state.	Project		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Related Workforce Milestone: Perform detailed gap analysis between current state assessment of workforce and projected future state.	Project		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4a. Create recruitment plan and timeline for new hires.	Project		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4b. Identify and implement solutions for those positions that are difficult to recruit, train, or retain.	Project		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4c. Complete workforce budget analysis to establish revised workforce budget for the duration of DSRIP.	Project		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4d. Finalize current state assessment and obtain approval from the Board.	Project		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5A Identify all participating safety net primary care practices and associated providers	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 5B Establish HIT/HIE and Primary Care Transformation workgroups.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 5C1a) Engage and collaborate with RHIO HealtheConnections to define	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.							
Task 5c1b Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 5dProvide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.	Project		In Progress	08/04/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5e Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 5f Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5g Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 5h Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.	Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5i Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey.	Project		In Progress	09/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
• Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.							
Task 5j PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 5k Participating providers successfully complete MU Stage 2 attestation.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
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	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1a. PPS conducts analysis of the scope of services identified for a defined population for each PPS project	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1b. PPS develops preliminary value based payment option for each project based on previous step (Total Care, Bundled Care etc).	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1c. PPS conducts cost benefit analysis of projects and adjusts value based payment option (including services and population definition).	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1e. PPS develops measures and metrics for each value-based payment strategy.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1f. PPS collaborates with MCOs to assure proposed approaches are synergistic with MCO efforts.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1g. PPS engages partners to review and refine preliminary value-based approaches, with particular focus on assuring their participation.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1h. PPS engages MCOs in contractual discussions regarding each project, finalizes scope, population, approach, measures; resulting in contractual agreement with PPS.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1i. PPS engages partners in contractual discussions regarding each project; resulting in contractual agreement with PPS.	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task a. PPS develops standardized reporting and format.	Project		In Progress	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Project	N/A	In Progress	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation	Project		In Progress	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		In Progress	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1a. PPS conducts cost benefit analysis of 11 projects.	Project		In Progress	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1b. PPS develops provider level value-based payment parameters possibly including PMPM fees, metrics, reporting and periodic evaluation/review	Project		In Progress	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2a. PPS develops provider performance analysis	Project		In Progress	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 2b. PPS provides provider specific reports	Project		In Progress	04/01/2015	12/31/2016	12/31/2016	DY2 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	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	Project		In Progress	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task a. Develop CHW job descriptions and competencies	Project		In Progress	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task b. Develop standardized CHW training	Project		In Progress	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
c. Identify priority CBOs and clinical partners for CHW placement							
Task d. Enter into contracts with CBOs and clinical partners for CHW services (if necessary)	Project		In Progress	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task e. Develop or identify CHW-applicable performance measures and monitoring	Project		In Progress	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task f. Conduct performance reviews of CHW programs	Project		In Progress	04/01/2015	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 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 1a. Disseminate information and materials via professional membership organizations including websites and newsletters a minimum of annually										
Task 1b. Present information regarding PPS activities at professional membership annual meetings										
Task 1c. Meet with individual providers or organization representatives as requested										
Task 1d. Conduct annual review of project progress and IDS composition to identify key partner shortfalls necessary to accomplish goals										
Task 1e. Assess service gaps and explore contracting options or, when available, partner additions										
Task 1f. Develop partner contract, MOU and other agreement										

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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
templates.										
Task 1g. Identify partner-specific obligations including adoption of common system-wide clinical or operational protocols, and required reporting processes.										
Task 1h. Disseminate, negotiate and execute partner contracts, MOUs or agreements.										
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.										
Task PPS produces a list of participating HHs and ACOs.										
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task 2A. Conduct gap analysis of HHs, ACOs and PPS system integration.										
Task 2b. Develop organization-specific plans to incorporate HHs and ACOs into IDS										
Task 2c. Include HHs and ACOs in HIT/HIE assessment (see tasks below)										
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										

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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
reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task 4a. HIT/HIE strategy incorporates tracking processes										
Task 2. Related HIT IP Milestone: Develop roadmap to achieving secure clinical data sharing and interoperable systems across PPS network.										
Task 2a. Develop and present data sharing roadmap components to IT and Data Governance Board subcommittee including: HIE and data sharing current state assessment; data sharing rules and enforcement strategy; proposed technical standards for a common clinical data set; proposed training plan										
Task 2b. Obtain board approval for data sharing roadmap										
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.	0	0	0	0	7	15	22	30	40	45
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	30	60	90	120	150	180
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	1	2	3	5	7	9
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	6	12	18	24	30	36
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	3	7	12	18
Task PPS uses alerts and secure messaging functionality.										
Task a. Develop functional specifications for data exchange to support project requirements and use cases including										

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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
supported payloads and modes of exchange										
Task b. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange										
Task c. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task d. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms										
Task 5. Obtain board approval for data sharing rollout plan										
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	1	3	3	10	32	33
Task 1a. Work with providers and vendors to align requirements with implementation strategies										
Task 1b. Develop plans to help community providers assess and provide EHR solutions										
Task 2a. Identify all participating safety net primary care practices and associated providers										
Task 2b. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 2c1 Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements										

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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 2c2 Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 2d Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 2e Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 2f Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 2g Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 2h Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 2i Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
2j PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 2k Participating providers successfully complete MU Stage 2 attestation.										
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. Convene with project participants/providers to inventory registries that would be useful for the identification, stratification, and engagement of patients for the project										
Task 2. Work with project participants to define and inventory additional data required to facilitate care coordination among participating partners.										
Task 5. Finalize registry requirements, including inclusion/exclusion criteria and metric definitions.										
Task 6. Identify core data elements needed for registry/metric requirements as well as care coordination data and identify the expected sources of data.										
Task 7. Complete gap analysis to compare required data to currently available data.										
Task 8. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 9. Work with participating partners and their EMR vendors to identify local registry capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
Task 10. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 11. Finalize required functionality and select a PHM software vendor										
Task 12. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning)										
Task 13. Implement PHM roadmap										
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.	0	0	0	0	6	12	12	43	132	138
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 6a. Work with providers and vendors to align requirements with implementation strategies										
Task 6b. Develop plans to help community providers assess and provide EHR solutions										
Task 2. Related Workforce Milestone: Define target workforce state (in line with DSRIP program's goals)										
Task 3. Related Workforce Milestone: Create a workforce transition roadmap for achieving your defined target workforce state.										
Task 4. Related Workforce Milestone: Perform detailed gap analysis between current state assessment of workforce and projected future state.										
Task 4a. Create recruitment plan and timeline for new hires.										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 4b. Identify and implement solutions for those positions that are difficult to recruit, train, or retain.										
Task 4c. Complete workforce budget analysis to establish revised workforce budget for the duration of DSRIP.										
Task 4d. Finalize current state assessment and obtain approval from the Board.										
Task 5A Identify all participating safety net primary care practices and associated providers										
Task 5B Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 5C1a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.										
Task 5c1b Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 5dProvide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5e Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 5f Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 5g Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 5h Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 5i Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 5j PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 5k Participating providers successfully complete MU Stage 2 attestation.										
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 1a. PPS conducts analysis of the scope of services identified for a defined population for each PPS project										
Task 1b. PPS develops preliminary value based payment option for each project based on previous step (Total Care, Bundled Care etc).										
Task 1c. PPS conducts cost benefit analysis of projects and adjusts value based payment option (including services and population definition).										
Task 1e. PPS develops measures and metrics for each value-based										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
payment strategy.										
Task 1f. PPS collaborates with MCOs to assure proposed approaches are synergistic with MCO efforts.										
Task 1g. PPS engages partners to review and refine preliminary value-based approaches, with particular focus on assuring their participation.										
Task 1h. PPS engages MCOs in contractual discussions regarding each project, finalizes scope, population, approach, measures; resulting in contractual agreement with PPS.										
Task 1i. PPS engages partners in contractual discussions regarding each project; resulting in contractual agreement with PPS.										
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 a. PPS develops standardized reporting and format.										
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 1a. PPS conducts cost benefit analysis of 11 projects.										
Task 1b. PPS develops provider level value-based payment parameters possibly including PMPM fees, metrics, reporting and periodic evaluation/review										
Task 2a. PPS develops provider performance analysis										
Task 2b. PPS provides provider specific reports										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 #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 a. Develop CHW job descriptions and competencies										
Task b. Develop standardized CHW training										
Task c. Identify priority CBOs and clinical partners for CHW placement										
Task d. Enter into contracts with CBOs and clinical partners for CHW services (if necessary)										
Task e. Develop or identify CHW-applicable performance measures and monitoring										
Task f. Conduct performance reviews of CHW programs										

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 1a. Disseminate information and materials via professional membership organizations including websites and newsletters a minimum of annually										
Task 1b. Present information regarding PPS activities at professional membership annual meetings										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 1c. Meet with individual providers or organization representatives as requested										
Task 1d. Conduct annual review of project progress and IDS composition to identify key partner shortfalls necessary to accomplish goals										
Task 1e. Assess service gaps and explore contracting options or, when available, partner additions										
Task 1f. Develop partner contract, MOU and other agreement templates.										
Task 1g. Identify partner-specific obligations including adoption of common system-wide clinical or operational protocols, and required reporting processes.										
Task 1h. Disseminate, negotiate and execute partner contracts, MOUs or agreements.										
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.										
Task PPS produces a list of participating HHs and ACOs.										
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task 2A. Conduct gap analysis of HHs, ACOs and PPS system integration.										
Task 2b. Develop organization-specific plans to incorporate HHs and ACOs into IDS										
Task 2c. Include HHs and ACOs in HIT/HIE assessment (see tasks below)										
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
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 4a. HIT/HIE strategy incorporates tracking processes										
Task 2. Related HIT IP Milestone: Develop roadmap to achieving secure clinical data sharing and interoperable systems across PPS network.										
Task 2a. Develop and present data sharing roadmap components to IT and Data Governance Board subcommittee including: HIE and data sharing current state assessment; data sharing rules and enforcement strategy; proposed technical standards for a common clinical data set; proposed training plan										
Task 2b. Obtain board approval for data sharing roadmap										
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.	53	75	75	75	75	75	75	75	75	75
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	210	299	299	299	299	299	299	299	299	299
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	11	13	13	13	13	13	13	13	13	13

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	42	58	58	58	58	58	58	58	58	58
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	24	32	32	32	32	32	32	32	32	32
Task PPS uses alerts and secure messaging functionality.										
Task a. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task b. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange										
Task c. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task d. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms										
Task 5. Obtain board approval for data sharing rollout plan										
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.	33	75	75	75	75	75	75	75	75	75
Task 1a. Work with providers and vendors to align requirements with implementation strategies										
Task 1b. Develop plans to help community providers assess and provide EHR solutions										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 2a. Identify all participating safety net primary care practices and associated providers										
Task 2b. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 2c1 Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements										
Task 2c2 Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 2d Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 2e Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 2f Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 2g Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 2h Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 2i Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 2j PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 2k Participating providers successfully complete MU Stage 2 attestation.										
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. Convene with project participants/providers to inventory registries that would be useful for the identification, stratification, and engagement of patients for the project										
Task 2. Work with project participants to define and inventory additional data required to facilitate care coordination among participating partners.										
Task 5. Finalize registry requirements, including inclusion/exclusion criteria and metric definitions.										
Task 6. Identify core data elements needed for registry/metric requirements as well as care coordination data and identify the expected sources of data.										
Task 7. Complete gap analysis to compare required data to currently available data.										
Task 8. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently 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
timely.										
Task 9. Work with participating partners and their EMR vendors to identify local registry capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
Task 10. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements										
Task 11. Finalize required functionality and select a PHM software vendor										
Task 12. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning)										
Task 13. Implement PHM roadmap										
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.	138	307	307	307	307	307	307	307	307	307
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 6a. Work with providers and vendors to align requirements with implementation strategies										
Task 6b. Develop plans to help community providers assess and provide EHR solutions										
Task 2. Related Workforce Milestone: Define target workforce state										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 line with DSRIP program's goals)										
Task 3. Related Workforce Milestone: Create a workforce transition roadmap for achieving your defined target workforce state.										
Task 4. Related Workforce Milestone: Perform detailed gap analysis between current state assessment of workforce and projected future state.										
Task 4a. Create recruitment plan and timeline for new hires.										
Task 4b. Identify and implement solutions for those positions that are difficult to recruit, train, or retain.										
Task 4c. Complete workforce budget analysis to establish revised workforce budget for the duration of DSRIP.										
Task 4d. Finalize current state assessment and obtain approval from the Board.										
Task 5A Identify all participating safety net primary care practices and associated providers										
Task 5B Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 5C1a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.										
Task 5c1b Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 5dProvide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5e Identify practice transformation champions to drive HIT/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
and PCMH implementation for each primary care practice.										
Task 5f Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 5g Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 5h Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 5i Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 5j PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 5k Participating providers successfully complete MU Stage 2 attestation.										
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 1a. PPS conducts analysis of the scope of services identified										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
for a defined population for each PPS project										
Task 1b. PPS develops preliminary value based payment option for each project based on previous step (Total Care, Bundled Care etc).										
Task 1c. PPS conducts cost benefit analysis of projects and adjusts value based payment option (including services and population definition).										
Task 1e. PPS develops measures and metrics for each value-based payment strategy.										
Task 1f. PPS collaborates with MCOs to assure proposed approaches are synergistic with MCO efforts.										
Task 1g. PPS engages partners to review and refine preliminary value-based approaches, with particular focus on assuring their participation.										
Task 1h. PPS engages MCOs in contractual discussions regarding each project, finalizes scope, population, approach, measures; resulting in contractual agreement with PPS.										
Task 1i. PPS engages partners in contractual discussions regarding each project; resulting in contractual agreement with PPS.										
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 a. PPS develops standardized reporting and format.										
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.										

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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 1a. PPS conducts cost benefit analysis of 11 projects.										
Task 1b. PPS develops provider level value-based payment parameters possibly including PMPM fees, metrics, reporting and periodic evaluation/review										
Task 2a. PPS develops provider performance analysis										
Task 2b. PPS provides provider specific reports										
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 a. Develop CHW job descriptions and competencies										
Task b. Develop standardized CHW training										
Task c. Identify priority CBOs and clinical partners for CHW placement										
Task d. Enter into contracts with CBOs and clinical partners for CHW services (if necessary)										
Task e. Develop or identify CHW-applicable performance measures and monitoring										
Task f. Conduct performance reviews of CHW programs										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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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.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, 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.	
Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
an integrated system and establish value-based payment arrangements.	
Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	
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.	

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

Instructions :

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

Milestone/Task Name	Status	Description	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 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.5 - IA Monitoring

Instructions :

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Central New York Care Collaborative, Inc. (PPS ID:8)

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.

1. Risk: Engagement of individuals who are high risk but who only have one chronic condition may be challenging. Potential Impact: If CNYCC is not able to identify individuals who are either currently using hospital services inappropriately or at high-risk of using services inappropriately than regardless of the value of the services that are provided, the project will not meet DSRIP goals. Mitigation: In order to mitigate this risk, indicators related to demographics, diagnoses, severity levels, and past utilization trends will be applied to properly identify patients or prospective patients. The introduction of a population health management platform will enable the systematic identification and tracking of high risk populations and the ability to track their care throughout the continuum. In the interim, the target population will be assessed via manual risk assessment tools. Collaborations at the community level among organizations who have relationships with eligible individuals will greatly assist with engagement.

2. Risk: Tracking all patients referred to this project and ensuring that providers across the PPS know patients are connected with care management will be a difficult, an issue compounded by the lack of EHRs among some providers. This project may endanger its own success if tracking systems are not adequate. Potential Impact: Without consistent and reliable HIT/HIE infrastructure or tools to track as many patients eligible for this project as possible, patients who could count towards the goals of this project may slip through the cracks of the infrastructure. Mitigation: HIT/HIE infrastructure must be brought up to working levels and accessible for partners involved in this project. Information exchange through the RHIO will be particularly key for partners to keep updated working records on patients referred to this program. Referral forms and tools must be provided to the community and distributed to all partners in this project who could end up referring to HHs.

3. Risk: Patients may decide to opt out of HH services or may be unresponsive to the efforts of HH care managers. Potential Impact: If patients refuse help from HHs or become disengaged from this project, they could exacerbate their chronic conditions, become more likely to be admitted or seek care in the ED, and harm both their own health and the ability of this project to meet its patient engagement numbers. Mitigation: Experience has shown that patients respond much more positively and openly to HH services when there are strong connections between HH care managers and primary care practices. When HH services or managers are highly recommended by providers, they tend to be more successful in reaching and working with patients. As much as HHs can connect with providers and partners, the more successful this project is likely to be in reaching patients.

4. Risk: Many partners and providers within CNYCC network are not fully aware of HHs and the services they provide. Potential Impact: If providers are not fully aware or cognizant of HH services, they will be less likely to refer their patients who may benefit from the use of this program. Many providers hear about this program, and think it refers to home care services. Both care coordination and project speed and scale may suffer if there is not adequate provider education. Mitigation: Partner outreach and education will be a major priority for the HHs in order to ensure success of this project. HHs will make time to "introduce themselves" to partners. Providers and their administrative staff will be engaged to ensure sufficient awareness of HH services so that consistent numbers of patients are referred to this program. HHs will also make efforts to

engage CBOs and other non-medical service providers to make sure connections can be made for patients in their own communities.

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IPQR Module 2.a.iii.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	162	0	0	0	0	0	0	0	32	64	96
Non-PCP Practitioners	580	0	0	0	0	0	0	0	116	232	348
Clinics	25	0	0	0	0	0	0	0	5	10	15
Health Home / Care Management	14	0	0	0	0	0	0	0	2	5	8
Behavioral Health	63	0	0	0	0	0	0	0	12	25	37
Substance Abuse	11	0	0	0	0	0	0	0	2	4	6
Pharmacies	4	0	0	0	0	0	0	0	0	1	2
Community Based Organizations	8	0	0	0	0	0	0	0	0	2	4
All Other	374	0	0	0	0	0	0	0	75	150	225
Total Committed Providers	**1,241**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**244**	**493**	**741**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**19.66**	**39.73**	**59.71**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	162	128	162	162	162	162	162	162	162	162	162
Non-PCP Practitioners	580	464	580	580	580	580	580	580	580	580	580
Clinics	25	20	25	25	25	25	25	25	25	25	25
Health Home / Care Management	14	11	14	14	14	14	14	14	14	14	14
Behavioral Health	63	40	63	63	63	63	63	63	63	63	63

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Substance Abuse	11	8	11	11	11	11	11	11	11	11	11
Pharmacies	4	3	4	4	4	4	4	4	4	4	4
Community Based Organizations	8	6	8	8	8	8	8	8	8	8	8
All Other	374	300	374	374	374	374	374	374	374	374	374
Total Committed Providers	**1,241**	**980**	**1,241**	**1,241**	**1,241**	**1,241**	**1,241**	**1,241**	**1,241**	**1,241**	**1,241**
Percent Committed Providers(%)		**78.97**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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Narrative Text :

Project requirement 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" will not be met until DY2Q4. Since that requirement is assigned to the project unit level, no individual providers can meet all of the project requirements (as set out in the project Plan Application) until that date. We believe this project requirement represents the "rate limiting" requirement for Project 2aiii because the installation and effective, advanced use of EHRs is a time consuming and difficult process. Providers must have an EHR installed, then create registry functionality and other PHM tools, develop criteria for the use of the registries, vet the use of said tools and criteria, and then actually use them, before they can truthfully indicate the ability to satisfy this requirement.

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Central New York Care Collaborative, Inc. (PPS ID:8)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	22,600

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	200	650	1,100	1,650	2,200	4,450	6,700	2,800	5,600
Percent of Expected Patient Engagement(%)	**0.00**	**0.88**	**2.88**	**4.87**	**7.30**	**9.73**	**19.69**	**29.65**	**12.39**	**24.78**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	11,150	16,700	5,650	11,300	16,950	22,600	5,650	11,300	16,950	22,600
Percent of Expected Patient Engagement(%)	**49.34**	**73.89**	**25.00**	**50.00**	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**

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Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 2.a.iii.4 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1.Convene PPS Health Homes in order to compile educational materials on DSRIP Health Home At Risk Intervention Program (HHRIP), for dissemination to PPS partner organizations.	Project		In Progress	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1a. Define eligible patient criteria	Project		In Progress	06/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task 1b. Develop preliminary risk assessment tool for patient stratification	Project		In Progress	06/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task 1b1 Submit preliminary risk tool for critique by other PPS partner organizations	Project		In Progress	06/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task 1c. Given the main risk factors of patients that fall within the at-risk group, based on the CNA, determine possible care coordination interventions that will engage them in care and reduce their risk factors.	Project		In Progress	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1d. Develop a standard care plan across Health Homes, including a standard set of DSRIP related goals/outcome, barriers to these goals, and options for addressing risk factors.	Project		In Progress	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1e. Develop a standard referral/screening form and process for PCP's and other partner organizations to use.	Project		In Progress	06/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 1f. Survey PPS partners for interest in being a referral source and potential downstream partner for HHRIP patients	Project		In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2. Outreach and educate partner organizations on HHRIP and referral process, begin engaging patients.	Project		In Progress	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Convene Project PIC or group of PPS partners to delineate roles of PCP/ACP in care model and to develop success measures.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Solicit feedback on care management plans and answer questions from each partner organization as requested.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 5. Lead Health Homes will train current and new downstream partners (including PCPs) on HHRIP protocols, so they can begin care management of eligible patients	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Determine baseline measures for main risk factors of HH at-risk group and develop target measures.	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 7. Develop a tool to track implementation of care management plans and progress of monitoring and evaluation measures.	Project		In Progress	08/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 8. Share all tools with cohort through webinars and in-person meetings as appropriate.	Project		In Progress	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	Provider	Primary Care Physicians	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify all providers/practices participating in project and identify those with NCQA PCMH 2011 Level 3 recognition.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 3a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
3b. Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate health home at risk strategies into PCMH baseline assessment tool and implementation strategy for primary care providers.							
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.	Project		In Progress	08/04/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.	Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.	Project		In Progress	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.							
Task 11. Participating providers successfully complete MU Stage 2 attestation.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
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	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Primary Care Physicians	In Progress	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 Non-PCP Practitioners	In Progress	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 Health Home / Care Management	In Progress	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	03/31/2018	DY3 Q4
Task 1. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Complete CNYCC partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities	Project		In Progress	04/04/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Convene with project participants/providers to define alerting use cases to help support project activities.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
7. Work with applicable project partners and their respective vendors to implement connectivity strategy							
Task 8. Roll out QE access to participating partner organizations, including patient lookup services and identified alerting use cases	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
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	08/04/2015	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	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Primary Care Physicians	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify all providers/practices participating in project and identify those with NCQA PCMH 2011 Level 3 recognition.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 3a) Define Meaningful Use Stage 2 requirements and align/incorporate health home at risk strategies with those requirements.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate cardiovascular disease management strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.							
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.	Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.	Project		In Progress	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 11. Participating providers successfully complete MU Stage 2 attestation.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
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	03/31/2018	03/31/2018	DY3 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	03/31/2018	03/31/2018	DY3 Q4
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners, including standards for defining the completion of a comprehensive care plans.	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2. Work with participating safety net providers and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.	Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Convene with project participants/providers to inventory registries that would be useful for the identification, stratification, and engagement of patients for the project	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Work with project participants to define and inventory additional data required to facilitate care coordination among participating partners.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Finalize registry requirements, including inclusion/exclusion criteria and metric definitions.	Project		In Progress	01/01/2016	02/28/2016	03/31/2016	DY1 Q4
Task 6. Identify core data elements needed for registry/metric requirements as well as care coordination data and identify the expected sources of data.	Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 7. Complete gap analysis to compare required data to currently available data.	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 8. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 9. Work with participating safety net providers and their EMR vendors to identify local registry capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task 10. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task 11. Finalize required functionality and select a PHM software vendor	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task 12. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning) and obtain board approval.	Project		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task 13. Implement PHM roadmap	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Develop a comprehensive care management plan for each patient to engage	Project	N/A	In Progress	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
him/her in care and to reduce patient risk factors.							
Task Procedures to engage at-risk patients with care management plan instituted.	Project		In Progress	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. With input from partner organizations in the PPS define care plan standards. Use existing care plans from current Health Homes program as a starting place.	Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Develop a draft process for the care team to initiate and track progress in the care plan in close partnership with the HH at-risk patients	Project		In Progress	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task 3. Review draft process and provide feedback	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Create a formal policy and procedure that outlines how the care team will complete and share the care plan with the patient.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 5. Create curriculum for training staff and providers on care plan process, and 'tip sheets' with screen shots to support learning	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 6. Roll-out training throughout partner organizations	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 7. Check-in with providers and care teams within one and three weeks after implementation to answer any questions	Project		In Progress	06/01/2016	08/31/2016	09/30/2016	DY2 Q2
Task 8. Audit target patient records to ensure care plans are being used	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 9. Adjust process and conduct additional training as needed	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 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	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Primary Care Physicians	In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Health Home / Care Management	In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Survey PPS organizations to establish PCP and Health Home providers who will be participating in the project.	Project		In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Task 2. Assign leads for each PCP group and its local HH to manage the partnership process	Project		In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Gather leads' contact information	Project		In Progress	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Establish and support communication among PCPs and their local HH via routine meetings between PCPs and HHs	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Research best-practices of successful partnership models around care coordination	Project		In Progress	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6. Develop/compile sample partnership Memoranda of Agreement that PCPs and HHs can utilize	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 7. Develop sample information sharing policies and procedures	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 8. Review sample MOA's and information sharing policies with HHs and PCPs to confirm structure	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 9. Share resources with all participating PCPs and HHs	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Set-up a mechanism for providing ongoing TA to partnerships	Project		In Progress	04/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task 11. Determine structure of partnership and establish formal partnership agreement that clearly delineate role of each party	Project		In Progress	04/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task 12. Cross train Health Home and Primary Care staff to ensure familiarity with the services/role that each plays in the management of the patients.	Project		In Progress	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 13. Determine baseline care coordination measures	Project		In Progress	03/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 14. Develop interim and long term strategies for collaborative care planning among project participants.	Project		In Progress	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 15. Implement strategies for collaborative care planning.	Project		In Progress	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 16. Monitor progress on care coordination measures	Project		In Progress	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish partnerships between the primary care providers, in concert with the	Project	N/A	In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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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.	Provider	Primary Care Physicians	In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Health Home / Care Management	In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Establish standard, DSRIP related patient goals and identify/categorize barriers patients' face in achieving those goals.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 2. Assess strengths and needs for your PCPs/local HH partnership, related to helping patients achieve DSRIP goals.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 3. Conduct environmental scan of local organizations and services provided in service area and create a directory of services.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Analyze results and determine overlap and gaps.	Project		In Progress	06/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 5. Reach out to organizations that fill gaps.	Project		In Progress	08/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task 6. Determine structure of partnership with network resource organizations and establish formal partnership agreement that clearly delineates role of each party, including as applicable use of EHRs and HIE system to facilitate and document partnerships	Project		In Progress	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 7. Create policies and procedures that support the partnership processes created including use of EHR and/or HIE system as applicable	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Determine baseline measures for established partnerships	Project		In Progress	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 9. Monitor progress on established measures	Project		In Progress	12/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction	Project	N/A	In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.	Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.	Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Use the CNA to identify the most common causes of adverse events in the population. Prioritize those for the creation of evidence-based care guidelines.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 2. Review existing evidence-based guidelines utilized by each provider/clinic as best practices according to literature.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 3. Determine the advantages and disadvantages of each set of guidelines and include these in a matrix	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Assist in determining how guidelines can be integrated into the EHR of most practices working close with clinic leads	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Create a guide and embed use of the guidelines into Health Home providers' workflow.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 6. Gather lessons learned from clinics that are already using the selected evidence-based guidelines and have integrated them into their EHRs	Project		In Progress	07/01/2016	08/31/2016	09/30/2016	DY2 Q2
Task 7. Train providers and Health Home staff on using the evidence-based guidelines selected and share best practices	Project		In Progress	09/01/2016	11/30/2016	12/31/2016	DY2 Q3
Task 8. Establish a process to ensure that providers are using the selected	Project		In Progress	04/01/2016	07/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
evidence-based guidelines							
Task 9. Monitor usage of evidence-based guidelines	Project		In Progress	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Provide additional training	Project		In Progress	07/01/2016	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 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.Convene PPS Health Homes in order to compile educational materials on DSRIP Health Home At Risk Intervention Program (HHRIP), for dissemination to PPS partner organizations.										
Task 1a. Define eligible patient criteria										
Task 1b. Develop preliminary risk assessment tool for patient stratification										
Task 1b1 Submit preliminary risk tool for critique by other PPS partner organizations										
Task 1c. Given the main risk factors of patients that fall within the at-risk group, based on the CNA, determine possible care coordination interventions that will engage them in care and reduce their risk factors.										
Task 1d. Develop a standard care plan across Health Homes, including a standard set of DSRIP related goals/outcome, barriers to these goals, and options for addressing risk factors.										
Task 1e. Develop a standard referral/screening form and process for PCP's and other partner organizations to use.										

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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 1f. Survey PPS partners for interest in being a referral source and potential downstream partner for HHRIP patients										
Task 2. Outreach and educate partner organizations on HHRIP and referral process, begin engaging patients.										
Task 3. Convene Project PIC or group of PPS partners to delineate roles of PCP/ACP in care model and to develop success measures.										
Task 4. Solicit feedback on care management plans and answer questions from each partner organization as requested.										
Task 5. Lead Health Homes will train current and new downstream partners (including PCPs) on HHRIP protocols, so they can begin care management of eligible patients										
Task 6. Determine baseline measures for main risk factors of HH at-risk group and develop target measures.										
Task 7. Develop a tool to track implementation of care management plans and progress of monitoring and evaluation measures.										
Task 8. Share all tools with cohort through webinars and in-person meetings as appropriate.										
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	3	6	6	22	69	72
Task 1. Identify all providers/practices participating in project and identify those with NCQA PCMH 2011 Level 3 recognition.										
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 3a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those										

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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 3b. Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate health home at risk strategies into PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										

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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 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
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.	0	0	0	0	8	16	24	32	40	48
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	24	48	72	96	110	134
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	1	2	3	4	5
Task PPS uses alerts and secure messaging functionality.										
Task 1. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 2. Complete CNYCC partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 3. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange										
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task 5. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms										

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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. Convene with project participants/providers to define alerting use cases to help support project activities.										
Task 7. Work with applicable project partners and their respective vendors to implement connectivity strategy										
Task 8. Roll out QE access to participating partner organizations, including patient lookup services and identified alerting use cases										
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	1	2	2	8	27	28
Task 1. Identify all providers/practices participating in project and identify those with NCQA PCMH 2011 Level 3 recognition.										
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 3a) Define Meaningful Use Stage 2 requirements and align/incorporate health home at risk strategies with those requirements.										
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate cardiovascular disease management strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE										

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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
and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
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.										

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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 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners, including standards for defining the completion of a comprehensive care plans.										
Task 2. Work with participating safety net providers and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Convene with project participants/providers to inventory registries that would be useful for the identification, stratification, and engagement of patients for the project										
Task 4. Work with project participants to define and inventory additional data required to facilitate care coordination among participating partners.										
Task 5. Finalize registry requirements, including inclusion/exclusion criteria and metric definitions.										
Task 6. Identify core data elements needed for registry/metric requirements as well as care coordination data and identify the expected sources of data.										
Task 7. Complete gap analysis to compare required data to currently available data.										
Task 8. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 9. Work with participating safety net providers and their EMR vendors to identify local registry capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
Task 10. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements										
Task 11. Finalize required functionality and select a PHM software vendor										
Task 12. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination										

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strategies (including method for collaborative care planning) and obtain board approval.										
Task 13. Implement PHM roadmap										
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. With input from partner organizations in the PPS define care plan standards. Use existing care plans from current Health Homes program as a starting place.										
Task 2. Develop a draft process for the care team to initiate and track progress in the care plan in close partnership with the HH at-risk patients										
Task 3. Review draft process and provide feedback										
Task 4. Create a formal policy and procedure that outlines how the care team will complete and share the care plan with the patient.										
Task 5. Create curriculum for training staff and providers on care plan process, and 'tip sheets' with screen shots to support learning										
Task 6. Roll-out training throughout partner organizations										
Task 7. Check-in with providers and care teams within one and three weeks after implementation to answer any questions										
Task 8. Audit target patient records to ensure care plans are being used										
Task 9. Adjust process and conduct additional training as needed										
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.										

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Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	0	0	0	20	60	100	162	162	162
Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	0	0	0	2	4	7	14	14	14
Task 1. Survey PPS organizations to establish PCP and Health Home providers who will be participating in the project.										
Task 2. Assign leads for each PCP group and its local HH to manage the partnership process										
Task 3. Gather leads' contact information										
Task 4. Establish and support communication among PCPs and their local HH via routine meetings between PCPs and HHs										
Task 5. Research best-practices of successful partnership models around care coordination										
Task 6. Develop/compile sample partnership Memoranda of Agreement that PCPs and HHs can utilize										
Task 7. Develop sample information sharing policies and procedures										
Task 8. Review sample MOA's and information sharing policies with HHs and PCPs to confirm structure										
Task 9. Share resources with all participating PCPs and HHs										
Task 10. Set-up a mechanism for providing ongoing TA to partnerships										
Task 11. Determine structure of partnership and establish formal partnership agreement that clearly delineate role of each party										
Task 12. Cross train Health Home and Primary Care staff to ensure familiarity with the services/role that each plays in the management of the patients.										
Task 13. Determine baseline care coordination measures										
Task 14. Develop interim and long term strategies for collaborative care planning among project participants.										

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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 15. Implement strategies for collaborative care planning.										
Task 16. Monitor progress on care coordination measures										
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	30	65	97	146	162	162	162
Task PPS has established partnerships to medical, behavioral health, and social services.	0	0	0	4	6	8	13	14	14	14
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task 1. Establish standard, DSRIP related patient goals and identify/categorize barriers patients' face in achieving those goals.										
Task 2. Assess strengths and needs for your PCPs/local HH partnership, related to helping patients achieve DSRIP goals.										
Task 3. Conduct environmental scan of local organizations and services provided in service area and create a directory of services.										
Task 4. Analyze results and determine overlap and gaps.										
Task 5. Reach out to organizations that fill gaps.										
Task 6. Determine structure of partnership with network resource organizations and establish formal partnership agreement that clearly delineates role of each party, including as applicable use of EHRs and HIE system to facilitate and document partnerships										
Task 7. Create policies and procedures that support the partnership processes created including use of EHR and/or HIE system as applicable										

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

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 8. Determine baseline measures for established partnerships										
Task 9. Monitor progress on established measures										
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. Use the CNA to identify the most common causes of adverse events in the population. Prioritize those for the creation of evidence-based care guidelines.										
Task 2. Review existing evidence-based guidelines utilized by each provider/clinic as best practices according to literature.										
Task 3. Determine the advantages and disadvantages of each set of guidelines and include these in a matrix										
Task 4. Assist in determining how guidelines can be integrated into the EHR of most practices working close with clinic leads										
Task 5. Create a guide and embed use of the guidelines into Health Home providers' workflow.										
Task 6. Gather lessons learned from clinics that are already using the selected evidence-based guidelines and have integrated them into their EHRs										

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

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 7. Train providers and Health Home staff on using the evidence-based guidelines selected and share best practices										
Task 8. Establish a process to ensure that providers are using the selected evidence-based guidelines										
Task 9. Monitor usage of evidence-based guidelines										
Task 10. Provide additional training										

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.Convene PPS Health Homes in order to compile educational materials on DSRIP Health Home At Risk Intervention Program (HHRIP), for dissemination to PPS partner organizations.										
Task 1a. Define eligible patient criteria										
Task 1b. Develop preliminary risk assessment tool for patient stratification										
Task 1b1 Submit preliminary risk tool for critique by other PPS partner organizations										
Task 1c. Given the main risk factors of patients that fall within the at-risk group, based on the CNA, determine possible care coordination interventions that will engage them in care and reduce their risk factors.										
Task 1d. Develop a standard care plan across Health Homes, including a standard set of DSRIP related goals/outcome, barriers to these goals, and options for addressing risk factors.										
Task										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
1e. Develop a standard referral/screening form and process for PCP's and other partner organizations to use.										
Task 1f. Survey PPS partners for interest in being a referral source and potential downstream partner for HHRIP patients										
Task 2. Outreach and educate partner organizations on HHRIP and referral process, begin engaging patients.										
Task 3. Convene Project PIC or group of PPS partners to delineate roles of PCP/ACP in care model and to develop success measures.										
Task 4. Solicit feedback on care management plans and answer questions from each partner organization as requested.										
Task 5. Lead Health Homes will train current and new downstream partners (including PCPs) on HHRIP protocols, so they can begin care management of eligible patients										
Task 6. Determine baseline measures for main risk factors of HH at-risk group and develop target measures.										
Task 7. Develop a tool to track implementation of care management plans and progress of monitoring and evaluation measures.										
Task 8. Share all tools with cohort through webinars and in-person meetings as appropriate.										
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	72	162	162	162	162	162	162	162	162	162
Task 1. Identify all providers/practices participating in project and identify those with NCQA PCMH 2011 Level 3 recognition.										
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 3a) Engage and collaborate with RHIO HealtheConnections to										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.										
Task 3b. Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate health home at risk strategies into PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey.										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
• Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
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.	56	64	64	64	64	64	64	64	64	64
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	158	187	187	187	187	187	187	187	187	187
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	6	7	7	7	7	7	7	7	7	7
Task PPS uses alerts and secure messaging functionality.										
Task 1. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 2. Complete CNYCC partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 3. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange										
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task 5. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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										
Task 6. Convene with project participants/providers to define alerting use cases to help support project activities.										
Task 7. Work with applicable project partners and their respective vendors to implement connectivity strategy										
Task 8. Roll out QE access to participating partner organizations, including patient lookup services and identified alerting use cases										
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.	28	64	64	64	64	64	64	64	64	64
Task 1. Identify all providers/practices participating in project and identify those with NCQA PCMH 2011 Level 3 recognition.										
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 3a) Define Meaningful Use Stage 2 requirements and align/incorporate health home at risk strategies with those requirements.										
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate cardiovascular disease management strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
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										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
able to track actively engaged patients for project milestone reporting.										
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners, including standards for defining the completion of a comprehensive care plans.										
Task 2. Work with participating safety net providers and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Convene with project participants/providers to inventory registries that would be useful for the identification, stratification, and engagement of patients for the project										
Task 4. Work with project participants to define and inventory additional data required to facilitate care coordination among participating partners.										
Task 5. Finalize registry requirements, including inclusion/exclusion criteria and metric definitions.										
Task 6. Identify core data elements needed for registry/metric requirements as well as care coordination data and identify the expected sources of data.										
Task 7. Complete gap analysis to compare required data to currently available data.										
Task 8. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 9. Work with participating safety net providers and their EMR vendors to identify local registry capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
Task 10. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements										
Task 11. Finalize required functionality and select a PHM software vendor										

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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 12. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning) and obtain board approval.										
Task 13. Implement PHM roadmap										
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. With input from partner organizations in the PPS define care plan standards. Use existing care plans from current Health Homes program as a starting place.										
Task 2. Develop a draft process for the care team to initiate and track progress in the care plan in close partnership with the HH at-risk patients										
Task 3. Review draft process and provide feedback										
Task 4. Create a formal policy and procedure that outlines how the care team will complete and share the care plan with the patient.										
Task 5. Create curriculum for training staff and providers on care plan process, and 'tip sheets' with screen shots to support learning										
Task 6. Roll-out training throughout partner organizations										
Task 7. Check-in with providers and care teams within one and three weeks after implementation to answer any questions										
Task 8. Audit target patient records to ensure care plans are being used										
Task 9. Adjust process and conduct additional training as needed										
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
should clearly delineate roles and responsibilities for both parties.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.	162	162	162	162	162	162	162	162	162	162
Task Each identified PCP establish partnerships with the local Health Home for care management services.	14	14	14	14	14	14	14	14	14	14
Task 1. Survey PPS organizations to establish PCP and Health Home providers who will be participating in the project.										
Task 2. Assign leads for each PCP group and its local HH to manage the partnership process										
Task 3. Gather leads' contact information										
Task 4. Establish and support communication among PCPs and their local HH via routine meetings between PCPs and HHs										
Task 5. Research best-practices of successful partnership models around care coordination										
Task 6. Develop/compile sample partnership Memoranda of Agreement that PCPs and HHs can utilize										
Task 7. Develop sample information sharing policies and procedures										
Task 8. Review sample MOA's and information sharing policies with HHs and PCPs to confirm structure										
Task 9. Share resources with all participating PCPs and HHs										
Task 10. Set-up a mechanism for providing ongoing TA to partnerships										
Task 11. Determine structure of partnership and establish formal partnership agreement that clearly delineate role of each party										
Task 12. Cross train Health Home and Primary Care staff to ensure familiarity with the services/role that each plays in the management of the patients.										
Task 13. Determine baseline care coordination measures										

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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 14. Develop interim and long term strategies for collaborative care planning among project participants.										
Task 15. Implement strategies for collaborative care planning.										
Task 16. Monitor progress on care coordination measures										
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.	162	162	162	162	162	162	162	162	162	162
Task PPS has established partnerships to medical, behavioral health, and social services.	14	14	14	14	14	14	14	14	14	14
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task 1. Establish standard, DSRIP related patient goals and identify/categorize barriers patients' face in achieving those goals.										
Task 2. Assess strengths and needs for your PCPs/local HH partnership, related to helping patients achieve DSRIP goals.										
Task 3. Conduct environmental scan of local organizations and services provided in service area and create a directory of services.										
Task 4. Analyze results and determine overlap and gaps.										
Task 5. Reach out to organizations that fill gaps.										
Task 6. Determine structure of partnership with network resource organizations and establish formal partnership agreement that clearly delineates role of each party, including as applicable use of EHRs and HIE system to facilitate and document partnerships										
Task 7. Create policies and procedures that support the partnership										

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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
processes created including use of EHR and/or HIE system as applicable										
Task 8. Determine baseline measures for established partnerships										
Task 9. Monitor progress on established measures										
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. Use the CNA to identify the most common causes of adverse events in the population. Prioritize those for the creation of evidence-based care guidelines.										
Task 2. Review existing evidence-based guidelines utilized by each provider/clinic as best practices according to literature.										
Task 3. Determine the advantages and disadvantages of each set of guidelines and include these in a matrix										
Task 4. Assist in determining how guidelines can be integrated into the EHR of most practices working close with clinic leads										
Task 5. Create a guide and embed use of the guidelines into Health Home providers' workflow.										
Task 6. Gather lessons learned from clinics that are already using the selected evidence-based guidelines and have integrated										

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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
them into their EHRs										
Task 7. Train providers and Health Home staff on using the evidence-based guidelines selected and share best practices										
Task 8. Establish a process to ensure that providers are using the selected evidence-based guidelines										
Task 9. Monitor usage of evidence-based guidelines										
Task 10. Provide additional training										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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.	
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.	
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.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
PCMH Level 3 standards and/or APCM.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
Develop a comprehensive care management plan for each patient 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.	
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).	
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.	

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IPQR Module 2.a.iii.5 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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 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.6 - 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.

1. Risk: Lack of primary care capacity in hospital catchment areas to which patients can be triaged. Triaging patients to community primary care providers will increase demand on already strained primary care and behavioral health services across CNYCC as well as required additional outpatient resources. Potential Impact: ED Triage is dependent on having primary care and other community-based providers available to see the patients in a timely manner. The lack of options particularly in the more rural areas could hinder progress on attaining the milestones for some of the projects. Mitigation: This will be addressed in multiple ways including implementing a comprehensive workforce strategy and encouraging integration of primary care and behavioral health.

2. Risk: Inadequate electronic communication capabilities could hinder the ability to coordinate and monitor the care of triaged patients. The PCPs, hospitals and community partners vary widely in the EHR systems they use – including not presently having any electronic systems. Potential Impact: One of the critical elements of the ED Triage project is to ensure that patients with non-urgent conditions are successfully hooked up with PCPs and that they receive the full breadth of services they need. Without adequate real-time information systems this may not happen. Mitigation: CNYCC benefits greatly from HealtheConnections, the local RHIO, which will enable providers to get up to speed more quickly, and to benefit from the expertise it offers.

3. Risk: The workforce is already limited in many of the CNYCC regions – particularly rural areas. Recruiting adequate numbers of appropriately trained patient navigators in the required timeframe could prove difficult. Potential Impact: The Patient Navigators are the lynchpins of this project. Without adequate staffing it will be difficult to efficiently and effectively triage patients. Mitigation: The first step in the project implementation is to assess the readiness and capacity of each of the hospitals and their community partners. Each will be assessed for staffing capacity. Implementation of the projects will be rolled-out starting where staffing is adequate and working with those partners who require more significant changes or augmentation. CNYCC benefits greatly from having three Health Homes in the PPS as well as multiple FQHCs that provide critical resources for the patient navigator function. Finally, the CNYCC Workforce Transition Workgroup is assessing workforce needs across all of CNYCC and will be an additional resource.

4. Risk: State and federal regulations and insurance liabilities create barriers to implementing ED Triage for some of the partners, for example rules that require SNF to transport a patient to the ED if they have fallen. Potential Impact: Concerns about liability will prevent critical partners from engaging with the project. Mitigation: CNYCC is actively engaged with the NYDOH in addressing the need for waivers to allow the partners to participate in the ED Triage project without fear of liability or regulatory issues.

5. Risk: Connecting to services outpatient or community services can be difficult outside of Monday-Friday, 9/5 working hours. Potential Impact: Patients may present back at the ED if outpatient or community services are not readily accessible. Mitigation: Stronger connections between hospital EDs and outpatient services will help to alleviate waiting times during non-traditional working hours. If hospital coordinators are more

cognizant of outpatient schedules and practices, patient wait-times may be cut. Additionally, community-based providers and health homes could pursue embedding staff within hospital EDs to further smooth transitions. As more practices obtain PCMH recognition, more open-access scheduling will become available to reduce appointment wait times.

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IPQR Module 2.b.iii.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Emergency Departments with Care Triage	11	0	0	0	0	0	0	0	2	4	6
Total Committed Providers	**11**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**4**	**6**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**18.18**	**36.36**	**54.55**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Emergency Departments with Care Triage	11	8	11	11	11	11	11	11	11	11	11
Total Committed Providers	**11**	**8**	**11**	**11**	**11**	**11**	**11**	**11**	**11**	**11**	**11**
Percent Committed Providers(%)		**72.73**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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Narrative Text :

Project requirement 1, "Establish ED care triage program for at-risk populations" may not be met by any participating EDs with care triage until DY2Q4. Since that requirement is assigned to the project unit level, no individual providers can meet all of the project requirements (as set out in the project Plan Application) until that date. We believe this project requirement represents the "rate limiting" requirement for Project 2biii because of the complexity of standing up such a triage program, particularly in rural areas. The connectivity between PCPs and EDs will be a challenge due to the lack of PCP availability in rural areas. EDs attempting to take on the transport/diversion of patients face an even more difficult challenge because of the protocols that must be developed and trained on, and the paradigm shift that their providers must go through.

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Central New York Care Collaborative, Inc. (PPS ID:8)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	16,100

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	1,600	1,600	3,200	4,800	9,600	4,000	8,000
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**9.94**	**9.94**	**19.88**	**29.81**	**59.63**	**24.84**	**49.69**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	12,000	16,100	4,000	8,000	12,000	16,100	4,000	8,000	12,000	16,100
Percent of Expected Patient Engagement(%)	**74.53**	**100.00**	**24.84**	**49.69**	**74.53**	**100.00**	**24.84**	**49.69**	**74.53**	**100.00**

Current File Uploads

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No Records Found

Narrative Text :

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 2.b.iii.4 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	03/31/2017	03/31/2017	DY2 Q4
Task Stand up program based on project requirements	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Conduct literature review of evidence-based ED Triage programs	Project		In Progress	04/01/2015	07/01/2015	09/30/2015	DY1 Q2
Task 2. Collect data on ED visits by diagnosis/acuity for each hospital; develop profiles for each hospital of patients by type of visit and geographic origin	Project		In Progress	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Conduct key informant interviews at each hospital to assess readiness and identify barriers to implementation. Must identify scope of triage program they would like to implement.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Conduct environmental survey to assess potential partners; map locations by type of provider including PCPs, home health agencies, clinics, ancillary service providers.	Project		In Progress	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5. Develop ED Triage manual including job descriptions; implementation strategies; community provider engagement; patient management protocols; medical information sharing protocols	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 6. Develop implementation plan for each hospital including workforce needs	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 7. Provide training on triage protocols with ED dedicated – Patient Navigators and ED medical providers (especially if planning to divert patients from ED).	Project		In Progress	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 8. Triage protocols and agreements developed with all hospitals with community partners including PCPs, home health agencies, clinics, and ancillary service providers.	Project		In Progress	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. All hospitals have compliant functioning ED Triage programs in place	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project	N/A	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Safety Net Primary Care Physicians	In Progress	08/04/2015	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	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Primary Care Physicians	In Progress	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 Hospitals	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify all providers/practices participating in project	Project		In Progress	08/04/2015	10/31/2015	12/31/2015	DY1 Q3
Task 2. Establish HIT/HIE and Primary Care Transformation work groups.	Project		In Progress	08/04/2015	10/31/2015	12/31/2015	DY1 Q3
Task 3. a) Define Meaningful Use Stage 2 requirements and align/incorporate ED care triage strategies with those requirements. b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate ED care triage strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.	Project		In Progress	08/04/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.							
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.	Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice.	Project		In Progress	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 11. Participating providers successfully complete MU Stage 2 attestation.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 12. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 13. Complete participating partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 14. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 15. Convene with project participants/providers to define alerting use cases (encounter notification services)	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 16. Work with applicable project partners and their respective vendors to implement connectivity strategy	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 17. Roll out QE services to participating partner organizations to support identified alerting use cases	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 18. Develop and implement orientation meetings with community PCPs	Project		In Progress	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 19. Execute triage and patient management agreements with PCPs at all hospitals	Project		In Progress	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 20. Identify/develop and implement procedures and protocols that connect the ED with community PCPs and track the transition of the patient from the ED to the PCP.	Project		In Progress	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 21. Develop and implement protocol for determining additional care management/community based (social) needs of triaged patients. Protocols must also establish connectivity between ED and PCP's/CBO's.	Project		In Progress	04/01/2016	03/31/2017	03/31/2017	DY2 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 primary care provider).	Project	N/A	In Progress	10/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task A defined process for triage of patients from patient navigators to non-emergency PCP and needed community support resources is in place.	Project		In Progress	10/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop process for identifying PCP's capacity and availability for appointments	Project		In Progress	10/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Develop rapid appointment making process – coordinated scheduling with PCPs	Project		In Progress	10/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Develop and implement patient-PCP best match protocol	Project		In Progress	10/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Train Patient Navigators on community resources and services, including Health Homes that are available to patients.	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Develop assessment procedure and checklist for identifying needed	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
community resources . Construct a "directory" of community resources.							
Task 6. Interface with existing PCP to schedule timely appointment and track completion	Project		In Progress	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Create educational materials meant to develop self-management skills, so that patients avoid unnecessary ED use in the future.	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 8. Develop method to track connection of patients with community resources	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
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	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 Hospitals	On Hold	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	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.	Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.	Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Identify core data elements needed for patient tracking requirements as well as care coordination data and identify the expected sources of data.	Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Complete gap analysis to compare required data to currently available data.	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 6. Work with participating partners and their EMR vendors to identify	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.							

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. Conduct literature review of evidence-based ED Triage programs										
Task 2. Collect data on ED visits by diagnosis/acuity for each hospital; develop profiles for each hospital of patients by type of visit and geographic origin										
Task 3. Conduct key informant interviews at each hospital to assess readiness and identify barriers to implementation. Must identify scope of triage program they would like to implement.										
Task 4. Conduct environmental survey to assess potential partners; map locations by type of provider including PCPs, home health agencies, clinics, ancillary service providers.										
Task 5. Develop ED Triage manual including job descriptions; implementation strategies; community provider engagement; patient management protocols; medical information sharing protocols										
Task 6. Develop implementation plan for each hospital including workforce needs										
Task 7. Provide training on triage protocols with ED dedicated – Patient Navigators and ED medical providers (especially if planning to divert patients from ED).										
Task 8. Triage protocols and agreements developed with all hospitals with community partners including PCPs, home health agencies, clinics, and ancillary service providers.										
Task 9. All hospitals have compliant functioning ED Triage programs										

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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
in place										
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	1	2	2	9	28	30
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	8	16	24	32	40	48
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	1	2	3	4	6	8
Task 1. Identify all providers/practices participating in project										
Task 2. Establish HIT/HIE and Primary Care Transformation work groups.										
Task 3. a) Define Meaningful Use Stage 2 requirements and align/incorporate ED care triage strategies with those requirements. b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate ED care triage strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2										

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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
measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
Task 12. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 13. Complete participating partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 14. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task 15. Convene with project participants/providers to define alerting use cases (encounter notification services)										
Task 16. Work with applicable project partners and their respective vendors to implement connectivity strategy										

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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 17. Roll out QE services to participating partner organizations to support identified alerting use cases										
Task 18. Develop and implement orientation meetings with community PCPs										
Task 19. Execute triage and patient management agreements with PCPs at all hospitals										
Task 20. Identify/develop and implement procedures and protocols that connect the ED with community PCPs and track the transition of the patient from the ED to the PCP.										
Task 21. Develop and implement protocol for determining additional care management/community based (social) needs of triaged patients. Protocols must also establish connectivity between ED and PCP's/CBO's.										
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. Develop process for identifying PCP's capacity and availability for appointments										
Task 2. Develop rapid appointment making process – coordinated scheduling with PCPs										
Task 3. Develop and implement patient-PCP best match protocol										
Task 4. Train Patient Navigators on community resources and services, including Health Homes that are available to 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
Task 5. Develop assessment procedure and checklist for identifying needed community resources . Construct a "directory" of community resources.										
Task 6. Interface with existing PCP to schedule timely appointment and track completion										
Task 7. Create educational materials meant to develop self-management skills, so that patients avoid unnecessary ED use in the future.										
Task 8. Develop method to track connection of patients with community resources										
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	2	5	7	11	11	11
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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements as well as care coordination data and identify the expected sources of data.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance										

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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
rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										

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. Conduct literature review of evidence-based ED Triage programs										
Task 2. Collect data on ED visits by diagnosis/acuity for each hospital; develop profiles for each hospital of patients by type of visit and geographic origin										
Task 3. Conduct key informant interviews at each hospital to assess readiness and identify barriers to implementation. Must identify scope of triage program they would like to implement.										
Task 4. Conduct environmental survey to assess potential partners; map locations by type of provider including PCPs, home health agencies, clinics, ancillary service providers.										
Task 5. Develop ED Triage manual including job descriptions; implementation strategies; community provider engagement; patient management protocols; medical information sharing protocols										
Task 6. Develop implementation plan for each hospital including workforce needs										
Task 7. Provide training on triage protocols with ED dedicated – Patient Navigators and ED medical providers (especially if planning to divert patients from ED).										
Task 8. Triage protocols and agreements developed with all hospitals with community partners including PCPs, home health										

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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
agencies, clinics, and ancillary service providers.										
Task 9. All hospitals have compliant functioning ED Triage programs in place										
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.	30	67	67	67	67	67	67	67	67	67
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	56	67	67	67	67	67	67	67	67	67
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	10	11	11	11	11	11	11	11	11	11
Task 1. Identify all providers/practices participating in project										
Task 2. Establish HIT/HIE and Primary Care Transformation work groups.										
Task 3. a) Define Meaningful Use Stage 2 requirements and align/incorporate ED care triage strategies with those requirements. b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate ED care triage strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
Task 12. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 13. Complete participating partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 14. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task 15. Convene with project participants/providers to define alerting use cases (encounter notification services)										

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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 16. Work with applicable project partners and their respective vendors to implement connectivity strategy										
Task 17. Roll out QE services to participating partner organizations to support identified alerting use cases										
Task 18. Develop and implement orientation meetings with community PCPs										
Task 19. Execute triage and patient management agreements with PCPs at all hospitals										
Task 20. Identify/develop and implement procedures and protocols that connect the ED with community PCPs and track the transition of the patient from the ED to the PCP.										
Task 21. Develop and implement protocol for determining additional care management/community based (social) needs of triaged patients. Protocols must also establish connectivity between ED and PCP's/CBO's.										
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. Develop process for identifying PCP's capacity and availability for appointments										
Task 2. Develop rapid appointment making process – coordinated scheduling with PCPs										
Task 3. Develop and implement patient-PCP best match protocol										

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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. Train Patient Navigators on community resources and services, including Health Homes that are available to patients.										
Task 5. Develop assessment procedure and checklist for identifying needed community resources . Construct a "directory" of community resources.										
Task 6. Interface with existing PCP to schedule timely appointment and track completion										
Task 7. Create educational materials meant to develop self-management skills, so that patients avoid unnecessary ED use in the future.										
Task 8. Develop method to track connection of patients with community resources										
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).	11	11	11	11	11	11	11	11	11	11
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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements as well as care coordination data and identify the expected sources of data.										
Task 4. Complete gap analysis to compare required data to currently										

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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
available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	
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	

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Prescribed Milestones Narrative Text

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

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IPQR Module 2.b.iii.5 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 2.b.iii.6 - IA Monitoring

Instructions :

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

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

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

Instructions :

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

1. Risk: Health care providers may not see the value in the Care Transitions Protocol in its entirety. They may choose to comply with some parts of the protocol and not with other parts. Potential Impact: This would reduce the impact of Care Transitions Protocol as a PPS wide tool, lead to confusion amongst providers and patients, and, ultimately result in potential avoidable readmissions. Mitigation: The Care Transitions Protocol will be developed with as broad an input process as possible. PDSA cycles will be used throughout the development, implementation and roll out to make improvements in the tool and process. There is also flexibility built into the provider roll out strategy to allow for some differences in the Care Transitions Protocol to account for regional differences in staffing, normal communication channels, and other differences that may exist in terms of provider mix, Intensive Transitions Team (ITT) composition, etc. Each roll out will be individually evaluated to ensure the Care Transition Protocol meets the needs of the providers and also functions to reduce avoidable admissions.

2. Risk: There may be provider concerns with applying Care Transitions Protocol to Medicaid population. Providers will need to treat Medicaid patients in a different manner than all other patients in terms of using the Care Transitions Protocol. This may be problematic for providers in identifying patients and being able to adequately track their patients. Potential Impact: Providers may have difficulty identifying and tracking which of their patients should be included in the Care Transitions program and which are not. This may result in practice inefficiency and frustration with the program. Mitigation: The ITT will be the focal point for identifying and tracking patients. The will provide communication to each provider included in the patient's care team and will track the patient's care within this team. This strategy is dependent on robust information technology and communication strategies.

3. Risk: Patients may be unwilling to participate in care transitions program. Patients may view the transition care program and the work of the ITT as intrusive. They may not be willing to share information amongst the various levels of community partners or may not want care providers coming to their homes or speaking with their families. They may also not comply or be unable to comply with discharge regimens owing to factors including health literacy, language issues, and lack of engagement. Potential Impact: Inability to promote a team approach with some patients. Decreased numbers of patients involved with care transitions. Reduced number of potential avoidable readmissions. Mitigation: The ITT will identify a provider whom the patient trusts (Primary Care Provider, nurse within PCP practice, etc.) to help make the case for following a care transitions plan, if possible. The ITT will work one-on-one with the patient to identify the relevant factors for non-compliance and identifying tailored solutions for each patient.

4. Risk: Fragmented care for patients with behavioral health issues, particularly for those with co-morbid medical and BH issues, due to the two the two service systems operating in silos. Potential Impact: Patients with BH issues have additional needs and barriers to care. If care transition plans do not take these into account, there may be lack of compliance with the plan and potential for avoidable readmissions. Mitigation: Patients with BH diagnoses are included in the target population for this project and a BH focused staff will be part of the ITT to ensure that BH issues are appropriately diagnosed and given adequate consideration in the development of a treatment plan upon discharge. A HH care manager may be embedded in the ITT to address the social issues driving readmissions in patients with BH issues.

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Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 2.b.iv.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	156	0	0	0	0	0	0	0	0	0	0
Non-PCP Practitioners	632	0	0	0	0	0	0	0	0	0	0
Hospitals	12	0	0	0	0	0	0	0	0	0	0
Health Home / Care Management	11	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	12	0	0	0	0	0	0	0	0	0	0
All Other	412	0	0	0	0	0	0	0	0	0	0
Total Committed Providers	**1,235**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	156	0	156	156	156	156	156	156	156	156	156
Non-PCP Practitioners	632	0	632	632	632	632	632	632	632	632	632
Hospitals	12	0	12	12	12	12	12	12	12	12	12
Health Home / Care Management	11	0	11	11	11	11	11	11	11	11	11
Community Based Organizations	12	0	12	12	12	12	12	12	12	12	12
All Other	412	0	412	412	412	412	412	412	412	412	412
Total Committed Providers	**1,235**	**0**	**1,235**	**1,235**	**1,235**	**1,235**	**1,235**	**1,235**	**1,235**	**1,235**	**1,235**
Percent Committed Providers(%)		**0.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Project requirement 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," which includes as a metric/deliverable "A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Home" will likely not be met until outcomes data is being generated by the project that will enable negotiations with MCOs. Since that requirement is assigned to the project unit level, no individual providers can meet all of the project requirements (as set out in the project Plan Application) until that date. We believe this project requirement represents the "rate limiting" requirement for Project 2biv because the nature of the interaction with Managed Care to this end will be to describe the penetration of the project into the system (extent to which other requirements have already been completed among partners) and the cost benefit analysis, requiring adequate and representative outcome data to be collected which will occur late in the DSRIP period. For example, DY2Q4's claims window for which outcome measures will be computed (Measurement Year 2) is July 1, 2015 to June 30, 2016, which is the earliest MY during which project implementation will occur. It seems unlikely that adequate outcome data will be available until at least DY3Q4, which is also the deadline for all project requirements being met by all participating providers.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	13,200

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	600	1,320	825	1,650	2,475	3,300	1,650	3,300
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**4.55**	**10.00**	**6.25**	**12.50**	**18.75**	**25.00**	**12.50**	**25.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	4,950	6,600	3,300	6,600	9,900	13,200	3,300	6,600	9,900	13,200
Percent of Expected Patient Engagement(%)	**37.50**	**50.00**	**25.00**	**50.00**	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 2.b.iv.4 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	03/31/2017	03/31/2017	DY2 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	08/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Update Literature Review of evidence-based readmission reduction program and best practices	Project		In Progress	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Present most recent research to the Project Implementation Collaboratives	Project		In Progress	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Hospitals collect and assess data on patient volume and mix for readmissions	Project		In Progress	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Project Implementation Collaboratives review other organizations' strategies/programs and perceived barriers and opportunities to existing strategies and programs and those that may occur as applied to the Medicaid population	Project		In Progress	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5. Create an inventory of existing chronic disease readmission reduction programs	Project		In Progress	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 6. Comparing results of updated literature review with evidence-based and best practices to the inventory of existing chronic disease readmission reduction programs, conduct partner-specific Capacity/Gap analysis	Project		In Progress	08/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 7. Modify models/tools to fill identified gaps, consider modifications to models/tools based on Medicare populations to better meet the needs of the Medicaid population; i.e. child care, timing of appointments, transportation	Project		In Progress	06/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	06/01/2015	10/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
8. Conduct PIC/Key Stakeholders meeting(s) to present findings and to identify and prioritize remaining gaps, develop plan to address each priority develop means to meet them through employment, new program development, etc.							
Task 9. Partners develop Multi-Disciplinary Transition Team	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 10. Develop standardized draft care transitions protocols and tool	Project		In Progress	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task 11. Share draft protocols with Project Implementation Collaboratives to elicit feedback	Project		In Progress	06/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task 12. Partners develop Roll-Out Plan for protocol implementation.	Project		In Progress	06/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task 13. Develop Protocol Implementation Training, include cultural sensitivity training in the curriculum	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 14. Train key staff; such as Intensive Transition Team members, Transition Coaches, Peer Coaches and Health Home Care Managers in protocol implementation	Project		In Progress	12/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 15. Conduct Roll-Out/Pilot meetings with Hospital, Home Care, PCPs and Non-PCP providers, Hospice, other facilities such as SNF, ICF, rehabilitation	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 16. Develop Evaluation Plan for protocol implementation and rapid cycle evaluation	Project		In Progress	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 17. Implement evaluation	Project		In Progress	03/01/2016	04/30/2016	06/30/2016	DY2 Q1
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	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
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	08/01/2016	03/31/2018	03/31/2018	DY3 Q4
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	08/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients	Project		In Progress	08/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and link them to services as required under ACA.							
Task 1. Share standardized draft care transitions protocols Revision A with Medicaid Managed Care Organizations and Health Homes	Project		In Progress	04/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task 2. Present draft protocols Revision A during a meeting with Medicaid Managed Care Organizations	Project		In Progress	04/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task 3. Present draft protocols Revision A during a meeting with Health Homes	Project		In Progress	04/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task 4. Using feedback from Medicaid Managed Care Organizations and Health Homes, further revise protocols (Revision B)	Project		In Progress	05/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task 5.Draft protocols Revision B shared with Key Stakeholders	Project		In Progress	06/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 6. Final protocols shared with Medicaid Managed Care Organizations and Health Homes	Project		In Progress	07/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 9. Develop process to identify Health-Home eligible patients and link them to services as required under ACA	Project		In Progress	09/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #3 Ensure required social services participate in the project.	Project	N/A	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Include Community-Based organizations and Social Services agencies in the Multi-Disciplinary Transition Team	Project		In Progress	04/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 2. Include provision of required network social services, including medically tailored home food services, in care transitions	Project		In Progress	04/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Present draft protocol Revision during meeting of Community-Based organizations and Social Services	Project		In Progress	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task 4. Collect feedback from Community-Based organizations and Social Services and revise protocols as necessary	Project		In Progress	04/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task 5. Communicate final revisions of protocols with Multi-Disciplinary Transition Team	Project		In Progress	04/01/2015	08/31/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 6. Conduct Roll-Out/Pilot meetings with Community-Based Organizations, Social Services and All Other Organizations	Project		In Progress	06/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Conduct Evaluation of Social Service Agency participation in project and/or include in rapid cycle evaluation approach.	Project		In Progress	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8. Present findings of Social Service Agency participation evaluation to Key Stakeholders and propose improvements to increase participation as necessary	Project		In Progress	04/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task 9. Include agreed upon improvements in protocols	Project		In Progress	05/01/2016	05/31/2016	06/30/2016	DY2 Q1
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	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Primary Care Physicians	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Non-PCP Practitioners	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospitals	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 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		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A. Develop policies and procedures for early notification of planned discharges	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task B. Include program in each facility that allows case managers access to visit patients in the hospital and provide care transition services	Project		In Progress	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
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	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	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
EHR or updated in primary care provider record.							
Task 2. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Complete participating partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Establish rapid cycle evaluation to monitor adherence	Project		In Progress	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6. Work with applicable project partners and their respective vendors to implement connectivity strategy	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Establish rapid cycle evaluation to monitor adherence	Project		In Progress	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.	Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.	Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Identify core data elements needed for patient tracking requirements as well	Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
as care coordination data and identify the expected sources of data.							
Task 4. Complete gap analysis to compare required data to currently available data.	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.	Project		In Progress	09/01/2015	08/31/2016	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. Update Literature Review of evidence-based readmission reduction program and best practices										
Task 2. Present most recent research to the Project Implementation Collaboratives										
Task 3. Hospitals collect and assess data on patient volume and mix for readmissions										
Task 4. Project Implementation Collaboratives review other organizations' strategies/programs and perceived barriers and opportunities to existing strategies and programs and those that may occur as applied to the Medicaid population										
Task 5. Create an inventory of existing chronic disease readmission reduction programs										
Task 6. Comparing results of updated literature review with evidence-based and best practices to the inventory of existing chronic										

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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
disease readmission reduction programs, conduct partner-specific Capacity/Gap analysis										
Task 7. Modify models/tools to fill identified gaps, consider modifications to models/tools based on Medicare populations to better meet the needs of the Medicaid population; i.e. child care, timing of appointments, transportation										
Task 8. Conduct PIC/Key Stakeholders meeting(s) to present findings and to identify and prioritize remaining gaps, develop plan to address each priority develop means to meet them through employment, new program development, etc.										
Task 9. Partners develop Multi-Disciplinary Transition Team										
Task 10. Develop standardized draft care transitions protocols and tool										
Task 11. Share draft protocols with Project Implementation Collaboratives to elicit feedback										
Task 12. Partners develop Roll-Out Plan for protocol implementation.										
Task 13. Develop Protocol Implementation Training, include cultural sensitivity training in the curriculum										
Task 14. Train key staff; such as Intensive Transition Team members, Transition Coaches, Peer Coaches and Health Home Care Managers in protocol implementation										
Task 15. Conduct Roll-Out/Pilot meetings with Hospital, Home Care, PCPs and Non-PCP providers, Hospice, other facilities such as SNF, ICF, rehabilitation										
Task 16. Develop Evaluation Plan for protocol implementation and rapid cycle evaluation										
Task 17. Implement evaluation										
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										

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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.										
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. Share standardized draft care transitions protocols Revision A with Medicaid Managed Care Organizations and Health Homes										
Task 2. Present draft protocols Revision A during a meeting with Medicaid Managed Care Organizations										
Task 3. Present draft protocols Revision A during a meeting with Health Homes										
Task 4. Using feedback from Medicaid Managed Care Organizations and Health Homes, further revise protocols (Revision B)										
Task 5.Draft protocols Revision B shared with Key Stakeholders										
Task 6. Final protocols shared with Medicaid Managed Care Organizations and Health Homes										
Task 9. Develop process to identify Health-Home eligible patients and link them to services as required under ACA										
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. Include Community-Based organizations and Social Services agencies in the Multi-Disciplinary Transition Team										
Task 2. Include provision of required network social services, including medically tailored home food services, in care transitions										
Task 3. Present draft protocol Revision during meeting 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
Community-Based organizations and Social Services										
Task 4. Collect feedback from Community-Based organizations and Social Services and revise protocols as necessary										
Task 5. Communicate final revisions of protocols with Multi-Disciplinary Transition Team										
Task 6. Conduct Roll-Out/Pilot meetings with Community-Based Organizations, Social Services and All Other Organizations										
Task 7. Conduct Evaluation of Social Service Agency participation in project and/or include in rapid cycle evaluation approach.										
Task 8. Present findings of Social Service Agency participation evaluation to Key Stakeholders and propose improvements to increase participation as necessary										
Task 9. Include agreed upon improvements in protocols										
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	0	0	0	78	156	156	156
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	0	316	632	632	632
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	0	6	12	12	12
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 A. Develop policies and procedures for early notification of planned discharges										
Task B. Include program in each facility that allows case managers access to visit patients in the hospital and provide care transition services										

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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 #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 2. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 3. Complete participating partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task 5. Establish rapid cycle evaluation to monitor adherence										
Task 6. Work with applicable project partners and their respective vendors to implement connectivity strategy										
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 2. Establish rapid cycle evaluation to monitor adherence										
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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors 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
identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements as well as care coordination data and identify the expected sources of data.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										

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. Update Literature Review of evidence-based readmission reduction program and best practices										
Task 2. Present most recent research to the Project Implementation Collaboratives										
Task 3. Hospitals collect and assess data on patient volume and mix for readmissions										
Task 4. Project Implementation Collaboratives review other organizations' strategies/programs and perceived barriers and opportunities to existing strategies and programs and those that may occur as applied to the Medicaid population										

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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. Create an inventory of existing chronic disease readmission reduction programs										
Task 6. Comparing results of updated literature review with evidence-based and best practices to the inventory of existing chronic disease readmission reduction programs, conduct partner-specific Capacity/Gap analysis										
Task 7. Modify models/tools to fill identified gaps, consider modifications to models/tools based on Medicare populations to better meet the needs of the Medicaid population; i.e. child care, timing of appointments, transportation										
Task 8. Conduct PIC/Key Stakeholders meeting(s) to present findings and to identify and prioritize remaining gaps, develop plan to address each priority develop means to meet them through employment, new program development, etc.										
Task 9. Partners develop Multi-Disciplinary Transition Team										
Task 10. Develop standardized draft care transitions protocols and tool										
Task 11. Share draft protocols with Project Implementation Collaboratives to elicit feedback										
Task 12. Partners develop Roll-Out Plan for protocol implementation.										
Task 13. Develop Protocol Implementation Training, include cultural sensitivity training in the curriculum										
Task 14. Train key staff; such as Intensive Transition Team members, Transition Coaches, Peer Coaches and Health Home Care Managers in protocol implementation										
Task 15. Conduct Roll-Out/Pilot meetings with Hospital, Home Care, PCPs and Non-PCP providers, Hospice, other facilities such as SNF, ICF, rehabilitation										
Task 16. Develop Evaluation Plan for protocol implementation and rapid cycle evaluation										
Task 17. Implement evaluation										

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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 #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. Share standardized draft care transitions protocols Revision A with Medicaid Managed Care Organizations and Health Homes										
Task 2. Present draft protocols Revision A during a meeting with Medicaid Managed Care Organizations										
Task 3. Present draft protocols Revision A during a meeting with Health Homes										
Task 4. Using feedback from Medicaid Managed Care Organizations and Health Homes, further revise protocols (Revision B)										
Task 5.Draft protocols Revision B shared with Key Stakeholders										
Task 6. Final protocols shared with Medicaid Managed Care Organizations and Health Homes										
Task 9. Develop process to identify Health-Home eligible patients and link them to services as required under ACA										
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. Include Community-Based organizations and Social Services agencies in the Multi-Disciplinary Transition Team										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 2. Include provision of required network social services, including medically tailored home food services, in care transitions										
Task 3. Present draft protocol Revision during meeting of Community-Based organizations and Social Services										
Task 4. Collect feedback from Community-Based organizations and Social Services and revise protocols as necessary										
Task 5. Communicate final revisions of protocols with Multi-Disciplinary Transition Team										
Task 6. Conduct Roll-Out/Pilot meetings with Community-Based Organizations, Social Services and All Other Organizations										
Task 7. Conduct Evaluation of Social Service Agency participation in project and/or include in rapid cycle evaluation approach.										
Task 8. Present findings of Social Service Agency participation evaluation to Key Stakeholders and propose improvements to increase participation as necessary										
Task 9. Include agreed upon improvements in protocols										
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.	156	156	156	156	156	156	156	156	156	156
Task Policies and procedures are in place for early notification of planned discharges.	632	632	632	632	632	632	632	632	632	632
Task Policies and procedures are in place for early notification of planned discharges.	12	12	12	12	12	12	12	12	12	12
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 A. Develop policies and procedures for early notification of										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
planned discharges										
Task B. Include program in each facility that allows case managers access to visit patients in the hospital and provide care transition services										
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 2. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 3. Complete participating partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task 5. Establish rapid cycle evaluation to monitor adherence										
Task 6. Work with applicable project partners and their respective vendors to implement connectivity strategy										
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 2. Establish rapid cycle evaluation to monitor adherence										
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										

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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
engaged patients for project milestone reporting.										
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements as well as care coordination data and identify the expected sources of data.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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.	
Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
appropriate post-discharge protocols are followed.	
Ensure required social services participate in the project.	
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.	
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	
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.	

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IPQR Module 2.b.iv.5 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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 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.6 - IA Monitoring

Instructions :

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

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

Instructions :

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

1. Risk: Inability to identify and capture individuals who are uninsured (UI), low-utilizers (LU) and non-utilizers (NU) and track them over time. This is a generally transient population, many of whom may not have a fixed address or telephone number. Many wish to remain anonymous and reluctance to impart personal information may also play a role in preventing follow up with patients. Potential Impact: This could result in a gradual loss to follow up and the inability to meet project milestones. Additional resources and outreach will be required to reach out and engage this population. Mitigation: To address this, CNYCC will engage with target population via multiple channels, including in-person and mobile/online engagement, as well as via clinical personnel and laypeople/peers in order to increase chances for establishing a meaningful connection. Specifically, CNYCC will partner with community based organizations (CBOs) and advocacy groups who have established a trusting relationship with the target population. The partnering CBOs are important resources for identifying those who are not engaged in care. Through these agencies, CNYCC will learn about the health care needs and preferences around engagement of the UI, LU, NU population directly to be able to devise a responsive follow up strategy. CNYCC will also utilize reports from Medicaid MCOs to help identify eligible individuals and also explore use of incentives for patients to participate in patient activation activities or reach certain thresholds and will conduct education campaign around potential benefits of coverage and use of preventive services. Initially, EHRs utilized by providers will be built out to accommodate tracking of the target population, including the development of registries and reports. For providers that do not have EHRs, other logging/tracking mechanisms will be developed. With the establishment of a population health management platform, tracking of these patients, including the care they receive throughout the continuum, will be centralized.

2. Risk: CNYCC may face cultural biases against seeking care or receiving services among the target population. In addition, low health literacy may be a barrier to effectively administer the PAM(R). Potential Impact: Often, the biases and barriers experienced by this population prevent them from seeking care. However, the success of this project rests on the ability to connect with the most vulnerable individuals who are on the periphery of the health care system. Mitigation: The PPS will engage members of the applicable communities, through community-based organizations, and train them in the PAM methodology. The CNYCC will administer the tool in several ways (e.g. spoken or read). For language-related literacy barriers, laypeople in the non-English speaking communities will be hired and trained. Resources in the community will be engaged early in the project to partner in meeting the needs for interpreter training and services.

3. Risk: It is anticipated that by successfully implementing patient activation activities, the volume of non-emergent care provided to UI, NU, and LU will provide a substantial increase in the demand for outpatient services. As a result, capacity constraints may be magnified beyond what is currently expected. Potential Impact: If the capacity of outpatient/primary care services are not able to meet the new demand for care, this will result in long waits, loss of potential new patients, loss of trust and interest by the target population. Mitigation: Forming strong partnerships with clinical providers and assisting them to implement needed strategies,such as hiring additional staff, conducting more telephonic visits, and ensuring adequate pre-visit planning to assign responsibilities appropriately throughout the care team, will be very important.

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IPQR Module 2.d.i.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
PAM(R) Providers	200	0	0	0	0	0	0	0	0	0	0
Total Committed Providers	**200**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
PAM(R) Providers	200	0	200	200	200	200	200	200	200	200	200
Total Committed Providers	**200**	**0**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**	**200**
Percent Committed Providers(%)		**0.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

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Narrative Text :

Project requirement 10, "Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons" references project outcome measures that cannot be expected to manifest until after a period of successful project implementation. Since that requirement is assigned to the project unit level, no individual providers can meet all of the project requirements (as set out in the project Plan Application) until that date. We believe this project requirement represents the "rate limiting" requirement for Project 2di because, given that CNYCC did not commit to engaging any patients in this project until DY2Q2 (September 30, 2016) and as a result of the offset between DSRIP years and their corresponding measurement years, we will not be able to demonstrate improvement in the outcome measure of interest until the following

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measurement year, which corresponds to reporting in DY3Q4. And while we will be able to gather this information for the Medicaid beneficiaries in our network through the Medicaid claims data provided to us by the State, this information on the uninsured will not be completely available until our population health management platform is fully operational, a complex infrastructural investment requiring a multi-year implementation timeline.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	22,300

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	0	0	5,600	9,750	13,900	5,550	11,100
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**25.11**	**43.72**	**62.33**	**24.89**	**49.78**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	16,700	22,300	5,550	11,100	16,700	22,300	5,550	11,100	16,700	22,300
Percent of Expected Patient Engagement(%)	**74.89**	**100.00**	**24.89**	**49.78**	**74.89**	**100.00**	**24.89**	**49.78**	**74.89**	**100.00**

Current File Uploads

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	Project	N/A	In Progress	08/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.	Project		In Progress	08/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task A. Conduct environmental scan of local CBOs, services provided and populations served	Project		In Progress	08/31/2015	11/30/2015	12/31/2015	DY1 Q3
Task B. Analyze results and determine which CBOs to partner/contract with given capacity and priorities	Project		In Progress	12/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task C. Establish formal partnership agreement or contract that clearly delineates role of each party (e.g., trainer/coach, surveyor, data collection & analysis), and reimbursement models including target measures to achieve	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task D. Hold regular meetings between PPS and CBOs to address hurdles, share successes and monitor progress on established measures	Project		In Progress	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Project	N/A	In Progress	09/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patient Activation Measure(R) (PAM(R)) training team established.	Project		In Progress	09/30/2015	03/31/2017	03/31/2017	DY2 Q4
Task A. Convene partner organizations to determine the range of skill and qualifications necessary for the PPS-wide training team, particularly experience in patient engagement, practice context reflects priority to engage UI/LU/NU population, including immigrants and non-English speakers, homeless,	Project		In Progress	09/30/2015	10/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
transitional housing.							
Task B. Generate a list of providers across the PPS who have been or plan to be trained in PAM® and engage in training team	Project		In Progress	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task C. Establish training team charter, including purpose, goals and activities, terms of commitment, expectations, deliverables, etc.	Project		In Progress	04/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task D. Create training manual and protocol for both training of implementers (ToI) and training of trainers (ToT); pilot and revise, translate as needed	Project		In Progress	05/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task E. Establish monitoring and evaluation process of PAM® training (quality assurance, performance measures)	Project		In Progress	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Project	N/A	In Progress	08/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	Project		In Progress	08/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task A. Elicit qualitative feedback from PPS participants and others as appropriate about perceived "hot spot" areas for IU/NU/LU beneficiaries	Project		In Progress	08/31/2015	10/31/2015	12/31/2015	DY1 Q3
Task B. Using Salient data, identify ZIP codes of residence & high volume providers of care to NU & LU beneficiaries	Project		In Progress	09/30/2015	10/31/2016	12/31/2016	DY2 Q3
Task C. From findings of research determine and map hot spot areas for UI, NU and LU in each county/community	Project		In Progress	11/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task D. Engage CBOs located in or near identified hotspots in to create standard elements of IU/NI/LU outreach strategy and to establish target measures for contracts	Project		In Progress	12/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task E. Contract with engaged CBOs to provide outreach to UI, NU and LU beneficiaries	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task F. Monitor progress on outreach activities	Project		In Progress	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Project	N/A	In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Community engagement forums and other information-gathering mechanisms established and performed.	Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A. Outline purpose of the listening sessions and steps to follow up on findings	Project		In Progress	10/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task B. Engage partnering CBOs to host listening sessions (community forums, focus groups) to document the health care needs of UI/LU/NU	Project		In Progress	10/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task C. Plan and schedule community forums with partnering CBOs to engage target populations – logistics, location, agenda, facilitation, topics for discussion (barriers to accessing health care system, enrollment, insurance options, etc.)	Project		In Progress	10/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task D. CBOs and other partners to conduct outreach/ promotion of community forums – emphasizing representation of target population (UI/LU/NU)	Project		In Progress	10/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task E. Develop a brief survey for listening session participants (include demographics, insurance status, utilization in last 12 months)	Project		In Progress	10/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task F. Conduct listening sessions as planned and document responses	Project		In Progress	11/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task G. Gather and analyze results of listening sessions, incorporate into training strategy & adjust methodology for future listening forums	Project		In Progress	12/01/2015	01/31/2016	03/31/2016	DY1 Q4
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Project	N/A	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task A. From list of hot spots, identify and engage providers located in the hot spot areas (partnering or contracted CBO) to receive PAM training	Project		In Progress	12/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task B. Plan PAM® training schedule	Project		In Progress	03/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task C. Contract with Insignia to license the PAM® tool and to deliver training on PAM® techniques	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task D. Evaluate PAM® training for quality assurance purposes	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task E. Provide technical assistance and booster sessions as needed	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	Project	N/A	In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task A. With MCO & CNYCC leadership, establish data sharing model; formalize via MOUs/contracts (if data not directly obtainable)	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task B. Following State opt-out period, establish procedures that permits PPS partners, with beneficiary consent (if required), to access Patient information in order to reconnect them with their assigned PCP (if data not more directly obtainable)	Project		In Progress	03/31/2016	04/30/2016	06/30/2016	DY2 Q1
Task C. Under formalized data sharing agreement, transmit lists of identified NU and LU beneficiaries with MCOs to obtain their assigned PCP (if data not directly obtainable)	Project		In Progress	05/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task D. Develop standardized talking points for CBOs, as well as educational materials on insurance coverage, language resources, and availability of primary and preventive care service among others to share with beneficiaries with appropriate State approval	Project		In Progress	03/01/2016	04/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task E. Distribute materials created to each participating PPS partner including CBOs	Project		In Progress	06/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task F. As they are identified during outreach and PAM® screening, reconnect NU/LU beneficiaries with their assigned PCP and provide educational materials	Project		In Progress	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	Project	N/A	In Progress	05/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).	Project		In Progress	05/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task A. Identify Medicaid patients according to status: uninsured, low- and non-utilizing members	Project		In Progress	05/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task B. Calculate baseline report for each cohort & set improvement target	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task C. Calculate improvement report for each cohort against baseline.	Project		In Progress	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Include beneficiaries in development team to promote preventive care.	Project	N/A	In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A. Create a Beneficiary Advisory Group representing UI, NU, LU patients	Project		In Progress	11/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task B. Establish role of the beneficiaries in patient activation/outreach/promotion of preventive care	Project		In Progress	09/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task C. Identify beneficiaries to be trained about PAM® and access and prevention	Project		In Progress	11/01/2015	11/30/2015	12/31/2015	DY1 Q3
Task D. Include 2-3 members from the Beneficiary Advisory Group to participate in the program development and awareness efforts	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Measure PAM(R) components, including:	Project	N/A	In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
• Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.							
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task A. Collect demographic and additional information from prospective sceenees to determine patient status (UI/NU/LU) and PCP assignment	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task B. Provide PAM® screening to UI, those without assigned PCPs, or whose	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PCP is a member of the PPS							
Task C. For NU/LU with PCPs not part of the PPS, counsel the patient about how to utilize their health care benefits and encourage them to reconnect with their assigned PCP (do not PAM® screen)	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task D. Each month, provide member engagement lists to relevant MCOs	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task E. Average first year and subsequent cohorts' PAM® scores to create baseline report, set improvement targets	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task F. After one year, average first year and subsequent cohorts' PAM® scores to create improvement report for each cohort against baseline.	Project		In Progress	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task G. Share data including member engagement lists by PAM® cohort, with key groups involved in the process.	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Project	N/A	In Progress	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Volume of non-emergent visits for UI, NU, and LU populations increased.	Project		In Progress	10/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task A. Determine best reports to pull to determine non-emergent care use per UI, NU and LU beneficiary and ensure data validation is conducted	Project		In Progress	10/01/2015	10/31/2015	12/31/2015	DY1 Q3
Task B. Baseline the volume of non-emergent care currently provided to NU and LU beneficiaries	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task C. Baseline the volume of non-emergent care currently provided to UI beneficiaries	Project		In Progress	03/31/2017	03/31/2018	03/31/2018	DY3 Q4
Task D. Pull reports on a quarterly basis to determine increase in non-emergent care by beneficiary cohorts & share information with key participants	Project		In Progress	09/30/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Project	N/A	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Provider	PAM(R) Providers	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Community navigators identified and contracted.							
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	Provider	PAM(R) Providers	In Progress	05/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task A. Determine CBOs with community navigators having capacity and skills to provide patient education regarding connectivity to healthcare coverage community health care resources, including for primary and preventive services	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task B. Identify CBOs with capacity to provide training to other community navigators regarding connectivity to healthcare coverage community health care resources, including for primary and preventive services	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task C. Contract with CBOs to provide training and/or to have their community navigators trained regarding connectivity to healthcare coverage community health care resources, including for primary and preventive services	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task D. Monitor training program and schedule booster sessions as needed	Project		In Progress	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Project	N/A	In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures for customer service complaints and appeals developed.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A. Develop a recommended process for Medicaid recipients and project participants to report complaints and received customer service	Project		In Progress	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task B. Create policy and procedure that documents the tailored process and assigns lead roles & educate participating partners regarding the policy & procedure	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task C. Monitor use of complaint system and follow-up	Project		In Progress	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Project	N/A	In Progress	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task List of community navigators formally trained in the PAM(R).	Provider	PAM(R) Providers	In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2A. Identify and engage community navigators to receive PAM training	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task B. Plan PAM® training schedule	Project		In Progress	03/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task C. Contract with Insignia to license the PAM® tool and to deliver training on PAM® techniques	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task D. Evaluate PAM® training for quality assurance purposes	Project		In Progress	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task E. Provide technical assistance and booster sessions as needed	Project		In Progress	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	Project	N/A	In Progress	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	Provider	PAM(R) Providers	In Progress	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task A. Create a navigator hand-off protocol at PAM® implementing sites/hot spots	Project		In Progress	04/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task B. Develop a workflow redesign to incorporate direct hand-offs to navigators at "hot spots", emergency departments, partnered CBOs and community events	Project		In Progress	05/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task C. Train providers and navigators in hand-off protocol providing supportive training materials	Project		In Progress	06/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task D. Ensure navigators are placed in highly visible locations to facilitate seamless hand –off	Project		In Progress	06/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task E. Implement hand-off protocol and monitor use data for quality improvement	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Project	N/A	In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Navigators educated about insurance options and healthcare resources available to populations in this project.	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task A. Create list of relevant insurance options and healthcare resources for UI, NU	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and LU beneficiaries							
Task B. As part of the training of community navigators addressed in Milestone #11 and #13, ensure to inform and educate them about insurance options and healthcare resources available to UI, NU, and LU beneficiaries	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task C. Update resources as necessary and maintain navigators current on updates	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Project	N/A	In Progress	10/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Timely access for navigator when connecting members to services.	Project		In Progress	10/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task A. Review existing policies and procedures for intake/scheduling at PPS primary care sites	Project		In Progress	10/31/2015	12/31/2015	12/31/2015	DY1 Q3
Task B. Revise policies and procedures, if needed, to accommodate calls from navigators (e.g., designate a phone line/intake staff to work with navigators)	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task C. Train intake/scheduling staff on new policies and procedures	Project		In Progress	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task D. Implement and monitor for quality improvement purposes	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	Project	N/A	In Progress	09/01/2015	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	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.	Project		In Progress	01/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task B. Convene with project participants/providers to inventory registries that would be useful for the identification, stratification, and engagement of patients for the project	Project		In Progress	03/01/2016	05/31/2016	06/30/2016	DY2 Q1
Task C. Finalize registry requirements, including inclusion/exclusion criteria and metric definitions.	Project		In Progress	05/01/2016	07/31/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task D. Work with participating partners and their EMR vendors to identify local registry capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task E. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task F. Finalize required functionality and select a PHM software vendor	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task G. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning) and obtain board approval.	Project		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task H. Implement PHM roadmap	Project		In Progress	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 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										
Task A. Conduct environmental scan of local CBOs, services provided and populations served										
Task B. Analyze results and determine which CBOs to partner/contract with given capacity and priorities										
Task C. Establish formal partnership agreement or contract that clearly delineates role of each party (e.g., trainer/coach, surveyor, data collection & analysis), and reimbursement models including target measures to achieve										
Task D. Hold regular meetings between PPS and CBOs to address										

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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
hurdles, share successes and monitor progress on established measures										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task A. Convene partner organizations to determine the range of skill and qualifications necessary for the PPS-wide training team, particularly experience in patient engagement, practice context reflects priority to engage UI/LU/NU population, including immigrants and non-English speakers, homeless, transitional housing.										
Task B. Generate a list of providers across the PPS who have been or plan to be trained in PAM® and engage in training team										
Task C. Establish training team charter, including purpose, goals and activities, terms of commitment, expectations, deliverables, etc.										
Task D. Create training manual and protocol for both training of implementers (ToI) and training of trainers (ToT); pilot and revise, translate as needed										
Task E. Establish monitoring and evaluation process of PAM® training (quality assurance, performance measures)										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task A. Elicit qualitative feedback from PPS participants and others as appropriate about perceived "hot spot" areas for IU/NU/LU beneficiaries										
Task B. Using Salient data, identify ZIP codes of residence & high volume providers of care to NU & LU beneficiaries										
Task C. From findings of research determine and map hot spot areas										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
for UI, NU and LU in each county/community										
Task D. Engage CBOs located in or near identified hotspots in to create standard elements of IU/NI/LU outreach strategy and to establish target measures for contracts										
Task E. Contract with engaged CBOs to provide outreach to UI, NU and LU beneficiaries										
Task F. Monitor progress on outreach activities										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task A. Outline purpose of the listening sessions and steps to follow up on findings										
Task B. Engage partnering CBOs to host listening sessions (community forums, focus groups) to document the health care needs of UI/LU/NU										
Task C. Plan and schedule community forums with partnering CBOs to engage target populations – logistics, location, agenda, facilitation, topics for discussion (barriers to accessing health care system, enrollment, insurance options, etc.)										
Task D. CBOs and other partners to conduct outreach/ promotion of community forums – emphasizing representation of target population (UI/LU/NU)										
Task E. Develop a brief survey for listening session participants (include demographics, insurance status, utilization in last 12 months)										
Task F. Conduct listening sessions as planned and document responses										
Task G. Gather and analyze results of listening sessions, incorporate into training strategy & adjust methodology for future listening forums										

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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 #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task A. From list of hot spots, identify and engage providers located in the hot spot areas (partnering or contracted CBO) to receive PAM training										
Task B. Plan PAM® training schedule										
Task C. Contract with Insignia to license the PAM® tool and to deliver training on PAM® techniques										
Task D. Evaluate PAM® training for quality assurance purposes										
Task E. Provide technical assistance and booster sessions as needed										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task A. With MCO & CNYCC leadership, establish data sharing model; formalize via MOUs/contracts (if data not directly obtainable)										

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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 B. Following State opt-out period, establish procedures that permits PPS partners, with beneficiary consent (if required), to access Patient information in order to reconnect them with their assigned PCP (if data not more directly obtainable)										
Task C. Under formalized data sharing agreement, transmit lists of identified NU and LU beneficiaries with MCOs to obtain their assigned PCP (if data not directly obtainable)										
Task D. Develop standardized talking points for CBOs, as well as educational materials on insurance coverage, language resources, and availability of primary and preventive care service among others to share with beneficiaries with appropriate State approval										
Task E. Distribute materials created to each participating PPS partner including CBOs										
Task F. As they are identified during outreach and PAM® screening, reconnect NU/LU beneficiaries with their assigned PCP and provide educational materials										
Milestone #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task A. Identify Medicaid patients according to status: uninsured, low- and non-utilizing members										
Task B. Calculate baseline report for each cohort & set improvement target										
Task C. Calculate improvement report for each cohort against baseline.										
Milestone #8 Include beneficiaries in development team to promote preventive 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
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task A. Create a Beneficiary Advisory Group representing UI, NU, LU patients										
Task B. Establish role of the beneficiaries in patient activation/outreach/promotion of preventive care										
Task C. Identify beneficiaries to be trained about PAM® and access and prevention										
Task D. Include 2-3 members from the Beneficiary Advisory Group to participate in the program development and awareness efforts										
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but										

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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
not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task A. Collect demographic and additional information from prospective sceenees to determine patient status (UI/NU/LU) and PCP assignment										
Task B. Provide PAM® screening to UI, those without assigned PCPs, or whose PCP is a member of the PPS										
Task C. For NU/LU with PCPs not part of the PPS, counsel the patient about how to utilize their health care benefits and encourage them to reconnect with their assigned PCP (do not PAM® screen)										
Task D. Each month, provide member engagement lists to relevant MCOs										
Task E. Average first year and subsequent cohorts' PAM® scores to create baseline report, set improvement targets										
Task F. After one year, average first year and subsequent cohorts' PAM® scores to create improvement report for each cohort against baseline.										
Task G. Share data including member engagement lists by PAM® cohort, with key groups involved in the process.										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task A. Determine best reports to pull to determine non-emergent										

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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
care use per UI, NU and LU beneficiary and ensure data validation is conducted										
Task B. Baseline the volume of non-emergent care currently provided to NU and LU beneficiaries										
Task C. Baseline the volume of non-emergent care currently provided to UI beneficiaries										
Task D. Pull reports on a quarterly basis to determine increase in non-emergent care by beneficiary cohorts & share information with key participants										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	0	0	0	0	50	100	150	160	170	180
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	0	0	0	0	50	100	150	160	170	180
Task A. Determine CBOs with community navigators having capacity and skills to provide patient education regarding connectivity to healthcare coverage community health care resources, including for primary and preventive services										
Task B. Identify CBOs with capacity to provide training to other community navigators regarding connectivity to healthcare coverage community health care resources, including for primary and preventive services										
Task C. Contract with CBOs to provide training and/or to have their community navigators trained regarding connectivity to healthcare coverage community health care resources, including for primary and preventive services										
Task D. Monitor training program and schedule booster sessions as needed										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										

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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 for customer service complaints and appeals developed.										
Task A. Develop a recommended process for Medicaid recipients and project participants to report complaints and received customer service										
Task B. Create policy and procedure that documents the tailored process and assigns lead roles & educate participating partners regarding the policy & procedure										
Task C. Monitor use of complaint system and follow-up										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	0	0	0	0	50	100	150	200	200	200
Task 2A. Identify and engage community navigators to receive PAM training										
Task B. Plan PAM® training schedule										
Task C. Contract with Insignia to license the PAM® tool and to deliver training on PAM® techniques										
Task D. Evaluate PAM® training for quality assurance purposes										
Task E. Provide technical assistance and booster sessions as needed										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	0	0	0	0	50	100	150	160	170	180
Task A. Create a navigator hand-off protocol at PAM® implementing sites/hot spots										

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Task B. Develop a workflow redesign to incorporate direct hand-offs to navigators at "hot spots", emergency departments, partnered CBOs and community events										
Task C. Train providers and navigators in hand-off protocol providing supportive training materials										
Task D. Ensure navigators are placed in highly visible locations to facilitate seamless hand –off										
Task E. Implement hand-off protocol and monitor use data for quality improvement										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare resources available to populations in this project.										
Task A. Create list of relevant insurance options and healthcare resources for UI, NU and LU beneficiaries										
Task B. As part of the training of community navigators addressed in Milestone #11 and #13, ensure to inform and educate them about insurance options and healthcare resources available to UI, NU, and LU beneficiaries										
Task C. Update resources as necessary and maintain navigators current on updates										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task A. Review existing policies and procedures for intake/scheduling at PPS primary care sites										
Task B. Revise policies and procedures, if needed, to accommodate calls from navigators (e.g., designate a phone line/intake staff to work with navigators)										

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Task C. Train intake/scheduling staff on new policies and procedures										
Task D. Implement and monitor for quality improvement purposes										
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task A. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task B. Convene with project participants/providers to inventory registries that would be useful for the identification, stratification, and engagement of patients for the project										
Task C. Finalize registry requirements, including inclusion/exclusion criteria and metric definitions.										
Task D. Work with participating partners and their EMR vendors to identify local registry capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
Task E. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements										
Task F. Finalize required functionality and select a PHM software vendor										
Task G. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning) and obtain board approval.										
Task H. Implement PHM roadmap										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.										
Task Partnerships with CBOs to assist in patient "hot-spotting" and engagement efforts as evidenced by MOUs, contracts, letters of agreement or other partnership documentation.										
Task A. Conduct environmental scan of local CBOs, services provided and populations served										
Task B. Analyze results and determine which CBOs to partner/contract with given capacity and priorities										
Task C. Establish formal partnership agreement or contract that clearly delineates role of each party (e.g., trainer/coach, surveyor, data collection & analysis), and reimbursement models including target measures to achieve										
Task D. Hold regular meetings between PPS and CBOs to address hurdles, share successes and monitor progress on established measures										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task A. Convene partner organizations to determine the range of skill and qualifications necessary for the PPS-wide training team, particularly experience in patient engagement, practice context reflects priority to engage UI/LU/NU population, including immigrants and non-English speakers, homeless, transitional housing.										
Task B. Generate a list of providers across the PPS who have been or plan to be trained in PAM® and engage in training team										
Task C. Establish training team charter, including purpose, goals and activities, terms of commitment, expectations, deliverables, etc.										

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Task D. Create training manual and protocol for both training of implementers (ToI) and training of trainers (ToT); pilot and revise, translate as needed										
Task E. Establish monitoring and evaluation process of PAM® training (quality assurance, performance measures)										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task A. Elicit qualitative feedback from PPS participants and others as appropriate about perceived "hot spot" areas for IU/NU/LU beneficiaries										
Task B. Using Salient data, identify ZIP codes of residence & high volume providers of care to NU & LU beneficiaries										
Task C. From findings of research determine and map hot spot areas for UI, NU and LU in each county/community										
Task D. Engage CBOs located in or near identified hotspots in to create standard elements of IU/NI/LU outreach strategy and to establish target measures for contracts										
Task E. Contract with engaged CBOs to provide outreach to UI, NU and LU beneficiaries										
Task F. Monitor progress on outreach activities										
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.										
Task Community engagement forums and other information-gathering mechanisms established and performed.										
Task A. Outline purpose of the listening sessions and steps to follow up on findings										
Task B. Engage partnering CBOs to host listening sessions (community forums, focus groups) to document the health 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
needs of UI/LU/NU										
Task C. Plan and schedule community forums with partnering CBOs to engage target populations – logistics, location, agenda, facilitation, topics for discussion (barriers to accessing health care system, enrollment, insurance options, etc.)										
Task D. CBOs and other partners to conduct outreach/ promotion of community forums – emphasizing representation of target population (UI/LU/NU)										
Task E. Develop a brief survey for listening session participants (include demographics, insurance status, utilization in last 12 months)										
Task F. Conduct listening sessions as planned and document responses										
Task G. Gather and analyze results of listening sessions, incorporate into training strategy & adjust methodology for future listening forums										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task A. From list of hot spots, identify and engage providers located in the hot spot areas (partnering or contracted CBO) to receive PAM training										
Task B. Plan PAM® training schedule										
Task C. Contract with Insignia to license the PAM® tool and to deliver training on PAM® techniques										
Task D. Evaluate PAM® training for quality assurance purposes										
Task E. Provide technical assistance and booster sessions as needed										
Milestone #6 Obtain list of PCPs assigned to NU and LU enrollees from										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.										
Task Procedures and protocols established to allow the PPS to work with the member's MCO and assigned PCP to help reconnect that beneficiary to his/her designated PCP.										
Task A. With MCO & CNYCC leadership, establish data sharing model; formalize via MOUs/contracts (if data not directly obtainable)										
Task B. Following State opt-out period, establish procedures that permits PPS partners, with beneficiary consent (if required), to access Patient information in order to reconnect them with their assigned PCP (if data not more directly obtainable)										
Task C. Under formalized data sharing agreement, transmit lists of identified NU and LU beneficiaries with MCOs to obtain their assigned PCP (if data not directly obtainable)										
Task D. Develop standardized talking points for CBOs, as well as educational materials on insurance coverage, language resources, and availability of primary and preventive care service among others to share with beneficiaries with appropriate State approval										
Task E. Distribute materials created to each participating PPS partner including CBOs										
Task F. As they are identified during outreach and PAM® screening, reconnect NU/LU beneficiaries with their assigned PCP and provide educational materials										

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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 #7 Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.										
Task For each PAM(R) activation level, baseline and set intervals toward improvement determined at the beginning of each performance period (defined by the state).										
Task A. Identify Medicaid patients according to status: uninsured, low- and non-utilizing members										
Task B. Calculate baseline report for each cohort & set improvement target										
Task C. Calculate improvement report for each cohort against baseline.										
Milestone #8 Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task A. Create a Beneficiary Advisory Group representing UI, NU, LU patients										
Task B. Establish role of the beneficiaries in patient activation/outreach/promotion of preventive care										
Task C. Identify beneficiaries to be trained about PAM® and access and prevention										
Task D. Include 2-3 members from the Beneficiary Advisory Group to participate in the program development and awareness efforts										
Milestone #9 Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score.										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
• Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task A. Collect demographic and additional information from prospective sceenees to determine patient status (UI/NU/LU) and PCP assignment										
Task B. Provide PAM® screening to UI, those without assigned PCPs, or whose PCP is a member of the PPS										
Task C. For NU/LU with PCPs not part of the PPS, counsel the patient about how to utilize their health care benefits and encourage them to reconnect with their assigned PCP (do not										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
PAM® screen)										
Task D. Each month, provide member engagement lists to relevant MCOs										
Task E. Average first year and subsequent cohorts' PAM® scores to create baseline report, set improvement targets										
Task F. After one year, average first year and subsequent cohorts' PAM® scores to create improvement report for each cohort against baseline.										
Task G. Share data including member engagement lists by PAM® cohort, with key groups involved in the process.										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										
Task Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task A. Determine best reports to pull to determine non-emergent care use per UI, NU and LU beneficiary and ensure data validation is conducted										
Task B. Baseline the volume of non-emergent care currently provided to NU and LU beneficiaries										
Task C. Baseline the volume of non-emergent care currently provided to UI beneficiaries										
Task D. Pull reports on a quarterly basis to determine increase in non-emergent care by beneficiary cohorts & share information with key participants										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	190	200	200	200	200	200	200	200	200	200
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including	190	200	200	200	200	200	200	200	200	200

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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
primary and preventive services), as well as patient education.										
Task A. Determine CBOs with community navigators having capacity and skills to provide patient education regarding connectivity to healthcare coverage community health care resources, including for primary and preventive services										
Task B. Identify CBOs with capacity to provide training to other community navigators regarding connectivity to healthcare coverage community health care resources, including for primary and preventive services										
Task C. Contract with CBOs to provide training and/or to have their community navigators trained regarding connectivity to healthcare coverage community health care resources, including for primary and preventive services										
Task D. Monitor training program and schedule booster sessions as needed										
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task A. Develop a recommended process for Medicaid recipients and project participants to report complaints and received customer service										
Task B. Create policy and procedure that documents the tailored process and assigns lead roles & educate participating partners regarding the policy & procedure										
Task C. Monitor use of complaint system and follow-up										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	200	200	200	200	200	200	200	200	200	200
Task 2A. Identify and engage community navigators to receive PAM training										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task B. Plan PAM® training schedule										
Task C. Contract with Insignia to license the PAM® tool and to deliver training on PAM® techniques										
Task D. Evaluate PAM® training for quality assurance purposes										
Task E. Provide technical assistance and booster sessions as needed										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	190	200	200	200	200	200	200	200	200	200
Task A. Create a navigator hand-off protocol at PAM® implementing sites/hot spots										
Task B. Develop a workflow redesign to incorporate direct hand-offs to navigators at "hot spots", emergency departments, partnered CBOs and community events										
Task C. Train providers and navigators in hand-off protocol providing supportive training materials										
Task D. Ensure navigators are placed in highly visible locations to facilitate seamless hand –off										
Task E. Implement hand-off protocol and monitor use data for quality improvement										
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.										
Task Navigators educated about insurance options and healthcare resources available to populations in this project.										
Task A. Create list of relevant insurance options and healthcare resources for UI, NU and LU beneficiaries										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task B. As part of the training of community navigators addressed in Milestone #11 and #13, ensure to inform and educate them about insurance options and healthcare resources available to UI, NU, and LU beneficiaries										
Task C. Update resources as necessary and maintain navigators current on updates										
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.										
Task Timely access for navigator when connecting members to services.										
Task A. Review existing policies and procedures for intake/scheduling at PPS primary care sites										
Task B. Revise policies and procedures, if needed, to accommodate calls from navigators (e.g., designate a phone line/intake staff to work with navigators)										
Task C. Train intake/scheduling staff on new policies and procedures										
Task D. Implement and monitor for quality improvement purposes										
Milestone #17 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task A. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task B. Convene with project participants/providers to inventory registries that would be useful for the identification, stratification, and engagement of patients for the project										
Task C. Finalize registry requirements, including inclusion/exclusion criteria and metric definitions.										

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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 D. Work with participating partners and their EMR vendors to identify local registry capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
Task E. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements										
Task F. Finalize required functionality and select a PHM software vendor										
Task G. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning) and obtain board approval.										
Task H. Implement PHM roadmap										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient activation techniques. The PPS must provide oversight and ensure that engagement is sufficient and appropriate.	
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	
Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot"	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
areas.	
Survey the targeted population about healthcare needs in the PPS' region.	
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	
Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	
Include beneficiaries in development team to promote preventive care.	
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
contact information when he/she visits the PPS designated facility or "hot spot" area for health service. • If the beneficiary is UI, does not have a registered PCP, or is attributed to a PCP in the PPS' network, assess patient using PAM(R) survey and designate a PAM(R) score. • Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	
Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	

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Central New York Care Collaborative, Inc. (PPS ID:8)

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

Instructions :

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

Milestone/Task Name	Status	Description	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 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.d.i.6 - IA Monitoring

Instructions :

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Central New York Care Collaborative, Inc. (PPS ID:8)

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.

1 Risk: Shortages of trained behavioral health providers is a threat to this project, including psychiatrists and other "prescribers." Historically, it has been difficult to recruit health care professionals to rural areas. Participant feedback from the CNYCC Partner meetings indicates PCPs are hesitant to conduct mental health screenings if referral services are lacking or there is a long wait to for an appointment. While integration is expected to resolve some of this access problem; there will be patients identified through the behavioral health screening who require more intense or higher level behavioral health services than can be accommodated in an integrated model. Providers fear identifying or intensifying a mental health condition that they are not trained to treat. When behavioral health screenings are routinely conducted as part of the integration plans, the number of patients requiring mental health services will increase thereby exacerbating the provider shortage. Potential Impact: The lack of mental health providers has the potential to destabilize integrated care. If there is a shortage of behavioral health providers, CNYCC will be unable to meet goals for integrating behavioral health and primary care, and patient health will suffer. Mitigation: Approaches are required to optimize the use of existing resources as well as to recruit new providers. One solution may be to explore best practices for the use of providers' time with regard to optimizing the ratio of walk-in appointments for urgent care and scheduled appointments. Tele-psychiatry is another way to maximize the use provider time by saving the time required to drive between sites because many providers contract to multiple health care organizations. An additional solution to the shortage of prescribers may result from the successful co-location of PC and BH, in which a primary care provider will feel more comfortable prescribing to a patient with a psychiatric colleague as a consult. A final approach to expand the work force for behavioral health services is to actively engage and recruit students in the NP psychiatry program.

2. Risk: Partial or incomplete integration of PC and BH is a risk, especially for sites that are newly integrating, due to differences in training and culture between BH and physical health. Simply co-locating services without developing evidence-based standards to integrate clinical practices and cultures will lead to services that are housed under the same roof, but lack coordination and provider support. A theme that arose during the Regional Partner Meetings was the necessity to integrate clinical cultures. Potential Impact: Poorly integrated services could result in possessiveness of patients, poor care coordination, and the perception that one practice type is inferior to the other. Any of these scenarios could hinder provider engagement in the project and result in low patient satisfaction. Mitigation: It takes time and training to learn how to share in the responsibility for a patient, to conduct warm hand-offs, and to develop joint care plans. CNYCC partners suggest that there is a central support team to support this activity; for example, employing a learning collaborative approach where all integrating practices join together to learn from one another as well as engage external training where needed. Clarification of the regulations for sharing patient information and interoperable EMRs will also facilitate the complexities of integration.

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IPQR Module 3.a.i.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	270	0	0	0	0	0	0	0	54	108	162
Non-PCP Practitioners	640	0	0	0	0	0	0	0	128	256	382
Clinics	37	0	0	0	0	0	0	0	7	15	22
Behavioral Health	81	0	0	0	0	0	0	0	16	32	48
Substance Abuse	15	0	0	0	0	0	0	0	3	6	9
Community Based Organizations	12	0	0	0	0	0	0	0	2	5	7
All Other	505	0	0	0	0	0	0	0	101	202	303
Total Committed Providers	**1,560**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**311**	**624**	**933**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**19.94**	**40.00**	**59.81**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	270	216	270	270	270	270	270	270	270	270	270
Non-PCP Practitioners	640	512	640	640	640	640	640	640	640	640	640
Clinics	37	30	37	37	37	37	37	37	37	37	37
Behavioral Health	81	64	81	81	81	81	81	81	81	81	81
Substance Abuse	15	12	15	15	15	15	15	15	15	15	15
Community Based Organizations	12	10	12	12	12	12	12	12	12	12	12
All Other	505	404	505	505	505	505	505	505	505	505	505

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Total Committed Providers	1,560	1,248	1,560	1,560	1,560	1,560	1,560	1,560	1,560	1,560	1,560
Percent Committed Providers(%)		80.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Project requirement 4, "Use of EHRs or other technical platforms to track all patients engaged in this project" will not be met until DY2Q4. Since that requirement is assigned to the project unit level, no individual providers can meet all of the project requirements (as set out in the project Plan Application) until that date. Behavioral health providers, especially, may struggle to implement EHRs. Additionally a metric/deliverable under this project is that participating providers' EHRs demonstrate integration of medical and behavior health record within individual records. In addition to the challenge of having basic EHRs, there are a lot of regulatory barriers related to the sharing of behavioral health records. Overcoming this challenge and ensuring compliance with regulations while meeting the DSRIP metric of an integrated record is anticipated to be the rate limiting step for Project 3ai

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Central New York Care Collaborative, Inc. (PPS ID:8)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	67,000

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	6,700	5,000	10,000	17,500	25,000	9,900	19,400
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**10.00**	**7.46**	**14.93**	**26.12**	**37.31**	**14.78**	**28.96**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	33,150	46,900	16,750	33,500	50,250	67,000	16,750	33,500	50,250	67,000
Percent of Expected Patient Engagement(%)	**49.48**	**70.00**	**25.00**	**50.00**	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 3.a.i.4 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	08/04/2015	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	Primary Care Physicians	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Behavioral Health	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify all participating safety net primary care practices and associated providers		Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.		Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 3.a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.		Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.		Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.		Project		In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5. Identify practice transformation champions to drive HIT/HIE and		Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PCMH implementation for each primary care practice.								
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.		Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7 Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.		Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.		Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.		Project		In Progress	09/01/2015	09/01/2017	09/30/2017	DY3 Q2
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.		Project		In Progress	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 11. Participating providers successfully complete MU Stage 2 attestation.		Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Co-locate behavioral health provider(s) within PCMH practices		Project		In Progress	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task		Project		In Progress	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
12. PCMH hires BH providers or PCMH contracts with BH organization								
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	06/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		In Progress	06/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1. Convene Project Implementation Collaborative (PIC)		Project		In Progress	06/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1a. Schedule meetings of PICs to develop integrated care practices		Project		In Progress	06/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2a. Collect protocols in use by practices		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2b. Review literature for evidence-based protocols related to integrated services		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2b. Review literature for evidence-based protocols related to integrated services		Project		In Progress	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task 2c. Recommend evidence-based protocols for review by CNYCC Clinical Governance Committee		Project		In Progress	03/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task 2d. Disseminate evidence-based protocols to all participating practices		Project		In Progress	03/01/2016	06/15/2016	06/30/2016	DY2 Q1
Task 3. Review OMH, OASAS, and DOH regulations, licensing, and reimbursement policies regarding integrated services		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 1	Project	N/A	In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Policies and procedures are in place to facilitate and document		Project		In Progress	06/15/2015	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
completion of screenings.								
Task Screenings are documented in Electronic Health Record.		Project		In Progress	06/15/2015	03/30/2018	03/31/2018	DY3 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	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Primary Care Physicians	In Progress	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Evidence-based protocols are in place to facilitate screening		Project		In Progress	06/15/2015	06/15/2016	06/30/2016	DY2 Q1
Task 1a. Identify target conditions to capture with screening		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1b. Identify screening tool(s) appropriate to target conditions		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1c. Identify workflows (i.e., who does screening, how are results shared with patient/care team, what happens with positive screen/negative screen, frequency of screen, where are screen results documented)		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1. Work with participating partners and their EMR vendors to identify alerting mechanisms and documentation implications.		Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 2. Implement alerting mechanisms and documentation requirements in EMR.		Project		In Progress	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	07/01/2015	03/30/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.								
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.		Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Identify core data elements needed for patient tracking requirements.		Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Complete gap analysis to compare required data to currently available data.		Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.		Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.		Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Milestone #5 Co-locate primary care services at behavioral health sites.	Model 2	Project	N/A	In Progress	08/04/2015	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	Primary Care Physicians	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Primary Care Physicians	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Behavioral Health	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify all participating safety net primary care practices and associated providers		Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.		Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task		Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
3a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.								
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.		Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.		Project		In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.		Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.		Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.		Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.		Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and		Project		In Progress	09/01/2015	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.								
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.		Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 11. Participating providers successfully complete MU Stage 2 attestation.		Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 12. Co-locate primary care services within behavioral health services		Project		In Progress	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 13. BH organization hires PC providers or BH organization contracts with PC practice		Project		In Progress	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process.		Project		In Progress	06/15/2015	06/15/2016	06/30/2016	DY2 Q1
Task 1. Convene Project Implementation Collaborative (PIC)		Project		In Progress	06/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1a. Schedule meetings of PICs to develop integrated care practices		Project		In Progress	06/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2a. Collect protocols in use by practices		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2b. Review literature for evidence-based protocols related to integrated services		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2c. Recommend evidence-based protocols for review by CNYCC		Project		In Progress	01/01/2016	03/01/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Clinical Governance Committee								
Task 2d. Disseminate evidence-based protocols to all participating practices		Project		In Progress	03/01/2016	06/15/2016	06/30/2016	DY2 Q1
Task 3. Review OMH, OASAS, and DOH regulations, licensing, and reimbursement policies regarding integrated services		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 2	Project	N/A	In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	06/15/2015	03/30/2018	03/31/2018	DY3 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	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Primary Care Physicians	In Progress	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 1. Evidence-based protocols are in place to facilitate screening		Project		In Progress	06/15/2015	06/15/2016	06/30/2016	DY2 Q1
Task 1a. Identify screening tool(s) appropriate for assessing primary care needs		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1b. Identify workflows (i.e., who does screening, how are results shared with patient/care team, what happens with positive screen/negative screen, frequency of screen, where are screen results documented)		Project		In Progress	06/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Work with participating partners and their EMR vendors to identify alerting mechanisms and documentation implications.		Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3. Implement alerting mechanisms and documentation requirements in EMR.		Project		In Progress	10/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 2	Project	N/A	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.		Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.		Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Identify core data elements needed for patient tracking requirements.		Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Complete gap analysis to compare required data to currently available data.		Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.		Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.		Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Primary Care Physicians	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task In alignment with the IMPACT model, treatment is adjusted based		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.								
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		On Hold	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	2	8	8	12	38	40
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	11	16	21	26	31	36	41	46
Task 1. Identify all participating safety net primary care practices and associated providers										
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 3.a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.										
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7 Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

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 11. Co-locate behavioral health provider(s) within PCMH practices										
Task 12. PCMH hires BH providers or PCMH contracts with BH organization										
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. Convene Project Implementation Collaborative (PIC)										
Task 1a. Schedule meetings of PICs to develop integrated care practices										
Task 2a. Collect protocols in use by practices										
Task 2b. Review literature for evidence-based protocols related to integrated services										
Task 2b. Review literature for evidence-based protocols related to integrated services										
Task 2c. Recommend evidence-based protocols for review by CNYCC Clinical Governance Committee										
Task 2d. Disseminate evidence-based protocols to all participating practices										
Task 3. Review OMH, OASAS, and DOH regulations, licensing, and reimbursement policies regarding integrated services										
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										

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

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

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
completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	5	15	30	45	60
Task 1. Evidence-based protocols are in place to facilitate screening										
Task 1a. Identify target conditions to capture with screening										
Task 1b. Identify screening tool(s) appropriate to target conditions										
Task 1c. Identify workflows (i.e., who does screening, how are results shared with patient/care team, what happens with positive screen/negative screen, frequency of screen, where are screen results documented)										
Task 1. Work with participating partners and their EMR vendors to identify alerting mechanisms and documentation implications.										
Task 2. Implement alerting mechanisms and documentation requirements in EMR.										
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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
participation.										
Task 3. Identify core data elements needed for patient tracking requirements.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										
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	4	16	16	24	76	80
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	33	43	53	63	73	83	93	103
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	11	16	21	26	31	36	41	46
Task 1. Identify all participating safety net primary care practices and associated providers										
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 3a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.										
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

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 12. Co-locate primary care services within behavioral health services										
Task 13. BH organization hires PC providers or BH organization contracts with PC practice										
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. Convene Project Implementation Collaborative (PIC)										
Task 1a. Schedule meetings of PICs to develop integrated care practices										
Task 2a. Collect protocols in use by practices										
Task 2b. Review literature for evidence-based protocols related to integrated services										
Task 2c. Recommend evidence-based protocols for review by CNYCC Clinical Governance Committee										
Task 2d. Disseminate evidence-based protocols to all participating practices										
Task 3. Review OMH, OASAS, and DOH regulations, licensing, and reimbursement policies regarding integrated services										
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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Central New York Care Collaborative, Inc. (PPS ID:8)

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	0	0	0	10	30	60	90	120
Task 1. Evidence-based protocols are in place to facilitate screening										
Task 1a. Identify screening tool(s) appropriate for assessing primary care needs										
Task 1b. Identify workflows (i.e., who does screening, how are results shared with patient/care team, what happens with positive screen/negative screen, frequency of screen, where are screen results documented)										
Task 2. Work with participating partners and their EMR vendors to identify alerting mechanisms and documentation implications.										
Task 3. Implement alerting mechanisms and documentation requirements in EMR.										
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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

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.	40	90	90	90	90	90	90	90	90	90
Task Behavioral health services are co-located within PCMH/APC practices and are available.	51	54	54	54	54	54	54	54	54	54
Task 1. Identify all participating safety net primary care practices and associated providers										
Task										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
2. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 3.a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.										
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7 Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, 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
continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
Task 11. Co-locate behavioral health provider(s) within PCMH practices										
Task 12. PCMH hires BH providers or PCMH contracts with BH organization										
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. Convene Project Implementation Collaborative (PIC)										
Task 1a. Schedule meetings of PICs to develop integrated care practices										
Task 2a. Collect protocols in use by practices										
Task 2b. Review literature for evidence-based protocols related to integrated services										
Task 2b. Review literature for evidence-based protocols related to integrated services										
Task 2c. Recommend evidence-based protocols for review by CNYCC Clinical Governance Committee										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 2d. Disseminate evidence-based protocols to all participating practices										
Task 3. Review OMH, OASAS, and DOH regulations, licensing, and reimbursement policies regarding integrated services										
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.	75	90	90	90	90	90	90	90	90	90
Task 1. Evidence-based protocols are in place to facilitate screening										
Task 1a. Identify target conditions to capture with screening										
Task 1b. Identify screening tool(s) appropriate to target conditions										
Task 1c. Identify workflows (i.e., who does screening, how are results shared with patient/care team, what happens with positive screen/negative screen, frequency of screen, where are screen results documented)										
Task 1. Work with participating partners and their EMR vendors to identify alerting mechanisms and documentation implications.										
Task 2. Implement alerting mechanisms and documentation requirements in EMR.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										

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Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task EHR 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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										
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.	80	180	180	180	180	180	180	180	180	180
Task Primary care services are co-located within behavioral Health practices and are available.	113	180	180	180	180	180	180	180	180	180
Task Primary care services are co-located within behavioral Health practices and are available.	51	51	51	51	51	51	51	51	51	51
Task 1. Identify all participating safety net primary care practices and associated providers										
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 3a) Engage and collaborate with RHIO HealtheConnections to define Meaningful Use Stage 2 requirements and align/incorporate PPS project strategies with those requirements.										
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate PPS project strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice. The project plan milestones include: • Policy and workflow development and implementation • Care team development and role definition; care management/self management support plan and implementation, and quality improvement plan and implementation. • Audit of implemented policies, processes, gaps in care, and continuous quality improvement • Generate reports, prepare QI data and preparation of NCQA										

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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
PCMH submission documentation for NCQA PCMH recognition survey. • Final document audit and submission of completed survey to NCQA and completion of Meaningful Use attestation.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
Task 12. Co-locate primary care services within behavioral health services										
Task 13. BH organization hires PC providers or BH organization contracts with PC practice										
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. Convene Project Implementation Collaborative (PIC)										
Task 1a. Schedule meetings of PICs to develop integrated care practices										
Task 2a. Collect protocols in use by practices										
Task 2b. Review literature for evidence-based protocols related to integrated services										
Task 2c. Recommend evidence-based protocols for review by CNYCC Clinical Governance Committee										
Task 2d. Disseminate evidence-based protocols to all participating practices										
Task 3. Review OMH, OASAS, and DOH regulations, licensing, 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
reimbursement policies regarding integrated services										
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.	150	180	180	180	180	180	180	180	180	180
Task 1. Evidence-based protocols are in place to facilitate screening										
Task 1a. Identify screening tool(s) appropriate for assessing primary care needs										
Task 1b. Identify workflows (i.e., who does screening, how are results shared with patient/care team, what happens with positive screen/negative screen, frequency of screen, where are screen results documented)										
Task 2. Work with participating partners and their EMR vendors to identify alerting mechanisms and documentation implications.										
Task 3. Implement alerting mechanisms and documentation requirements in EMR.										
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										

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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
engaged patients for project milestone reporting.										
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	0	0	0	0	0	0	0	0	0
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										
Task PPS identifies qualified Depression Care Manager (can be a										

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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
nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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Central New York Care Collaborative, Inc. (PPS ID:8)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Co-locate primary care services at behavioral health sites.	
Develop collaborative evidence-based standards of care including medication management and care engagement process.	
Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Implement IMPACT Model at Primary Care Sites.	
Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	
Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	
Designate a Psychiatrist meeting requirements of the IMPACT Model.	
Measure outcomes as required in the IMPACT Model.	
Provide "stepped care" as required by the IMPACT Model.	

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Prescribed Milestones Narrative Text

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

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IPQR Module 3.a.i.5 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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 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.6 - IA Monitoring

Instructions :

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Project 3.a.ii – Behavioral health community crisis stabilization services

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

Instructions :

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

1. Risk: Shortages of trained behavioral health (BH) providers, particularly psychiatrists and other "prescribers" is a threat to this project. The need for pediatric psychiatry and support services for families with children in crisis is particularly high. In some regions of CNY, inpatient BH services are so scant that families must travel to other parts of the State. The remote nature of communities poses a particular challenge in recruitment of such professionals, but it is a region-wide issue. Potential Impact: Without accessibility of trained behavioral health professionals, patients are more likely to reach a crisis condition and more likely to seek care at the ED or hospital. Mitigation: One means of addressing this challenge is to employ the use of telepsychiatry to link crisis intervention hubs to spoke locations and facilitate the sharing of specialized psychiatry resources. Telepsychiatry may be particularly beneficial in rural areas where it is difficult to recruit providers and patients and their families need to drive long distances in order to access mental health services.

2. Risk: The success of this project hinges on collaboration and coordination with police, school staff such as nurses and guidance counselors, as well as first responders. Training of police, school, and emergency responder personnel to the availability of crisis stabilization services and when and how to access such services is needed. Potential Impact: If key professionals are not trained in the existence of crisis stabilization services as part of the project implementation process they will not be aware of the crisis stabilization services and individuals in crisis will be unnecessarily brought to the ED or hospitalized. Mitigation: Some partners have already implemented such trainings and will provide direction and lessons learned. Mobile outreach services also exist in a number of other CNYCC counties. Partners have identified the Memphis Crisis Intervention Team model as a robust approach to implement crisis stabilization services. The Memphis model is an innovative police-based first responder program that diverts those in mental health crisis from incarceration and links them to mental health services. The program provides law enforcement based crisis intervention training to support individuals with mental illness. Mental Health First Aid trainings can also be offered to any provider or community support agency in an effort to increase awareness and improve prevention efforts.

3. Risk: Transportation is a challenge. This includes transportation to assessment and evaluation sites, to CPEP if needed, as well as to and from appointments outside of the crisis incident. A specific challenge for Lewis County is that there are no inpatient care or outpatient mental health services and the nearest transfer center is not in the PPS. Potential Impact: If transportation services are not available patients may not be able to access BH services when they are in a crisis state or outside of the crisis when ongoing care is required. Mitigation: ACT programs and Health Homes may serve as potential resources to alleviate transportation challenges for BH services and more broadly for other types of health care. For patients who are not in a crisis state, telepsychiatry is an approach to address the long distance that patients may need to travel to access services. Telepsychiatry may also be helpful in rural ERs that provide care to individuals in crisis, but do not have a psychiatrist on staff. Mobile Crisis Teams may be utilized to improve communication for parents, whose children are hospitalized in outside areas.

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IPQR Module 3.a.ii.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Expected Number of Crisis Intervention Programs Established	6	0	0	0	1	1	1	1	2	3	4
Total Committed Providers	**6**	**0**	**0**	**0**	**1**	**1**	**1**	**1**	**2**	**3**	**4**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**16.67**	**16.67**	**16.67**	**16.67**	**33.33**	**50.00**	**66.67**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Expected Number of Crisis Intervention Programs Established	6	5	6	6	6	6	6	6	6	6	6
Total Committed Providers	**6**	**5**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**	**6**
Percent Committed Providers(%)		**83.33**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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Narrative Text :

Fully deploying six (one in each county) mobile crisis teams (Project requirement 7, "Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff") is expected to be the rate limiting step in this project. It will be a gradual ramp up process, bringing on one new mobile team at a time to ensure that there is community buy-in, protocols in place, recruitment of team members, and training of team members. Additionally, the full deployment of a mobile crisis team means training of first responders and others in the community as to the availability and use of the team. Since that requirement is assigned to the project unit level, no individual providers can meet all of the project requirements (as set out in the project Plan Application) until that date.

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Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 3.a.ii.3 - Patient Engagement Speed

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	36,300

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	500	2,500	4,500	3,000	6,000	10,500	15,000	6,000	12,000
Percent of Expected Patient Engagement(%)	**0.00**	**1.38**	**6.89**	**12.40**	**8.26**	**16.53**	**28.93**	**41.32**	**16.53**	**33.06**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	18,600	27,200	9,050	18,100	27,200	36,300	9,050	18,100	27,200	36,300
Percent of Expected Patient Engagement(%)	**51.24**	**74.93**	**24.93**	**49.86**	**74.93**	**100.00**	**24.93**	**49.86**	**74.93**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

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Narrative Text :

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Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 3.a.ii.4 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	Project	N/A	In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1a. Convene Project Implementation Collaborative	Project		In Progress	06/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1b. PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Project		In Progress	06/15/2015	06/30/2016	06/30/2016	DY2 Q1
Task 1c. Crisis intervention program established in each of six counties	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	Project	N/A	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments)	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1a. Current ED diversion protocols shared with PIC and RPAC members	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1b. Assess literature for other evidence-based protocols related to ED diversion for patients in BH crisis	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1c. Recommend to Clinical Governance Committee protocols to adopt	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 1d. Project Managers adopt or revises protocol based on local needs	Project		In Progress	06/30/2016	03/31/2018	03/31/2018	DY3 Q4
Task 1e. Clinical Governance Committee and Project Managers review and updates diversion management protocol at least annually	Project		In Progress	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task 1f. First responders (EMS, police, schools, etc.) are trained in diversion protocols	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Project	N/A	In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. PPS staff, along with PPS partners as appropriate, meet with selected Medicaid Managed Care (MCO) organizations to explore agreements or pilots between the PPS and or individual partners within the PPS	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2. PPS staff, with partners and consultants as appropriate, conduct the necessary ground work required to establish sound VBP agreements between the MCOs and project 3aii partners, including work to understand service requirements, costs, impact of services on reducing MCO costs and inappropriate utilization, and payment	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task 3. Based on initial discussions with MCOs and groundwork conducted, PPS staff and 3aii partners engage MCO in negotiating the details of a pilot program that would cover the services provided by the 3aii project	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4. Assess impact of pilot and meet with MCO on periodic basis to perfect service requirements and core elements of VBP agreement so as to create the most appropriate inventive arrangements between the full breadth of appropriate clinical, social service, housing, and CBO partners,	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.	Project	N/A	In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated treatment care protocols are in place.	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Convene PICs	Project		In Progress	06/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2a. Collect protocols in use by partners	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2b. Review literature for evidence-based protocols related to project	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2c. Recommend evidence-based protocols for review by CNYCC Clinical Governance Committee	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2d. Disseminate evidence-based protocols to all participating partners	Project		In Progress	06/30/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2e. Clinical Governance Committee and Project Managers review and updates treatment care protocol at least annually	Project		In Progress	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Hospitals	In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. PPS compiles new and existing information on community and consumer need as well as the capacity of the current network of specialty psychiatric and crisis- oriented psychiatric services throughout service area so as to understand service related gaps	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. PPS conducts gap analysis to understand where additional specialty psychiatric and crisis- oriented psychiatric services are needed and establishes priorities with respect to these gaps	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3. PPS integrates work across its three mental, emotional, and behavioral health projects (3ai, 3aii, and 4aiii) so as to leverage resources and activities across projects	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Based on information collected on need and capacity, the PPS includes at least one hospital with specialty psychiatric services and crisis- oriented	Project		In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	Project	N/A	In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Hospitals	In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Clinics	In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	Provider	Safety Net Behavioral Health	In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	Project	N/A	In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.	Project		In Progress	06/15/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1a. Review operations, lessons learned, and protocols from current partner	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
mobile crisis teams							
Task 1b. Assess literature for other evidence-based protocols for mobile crisis teams	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 1c. Recommend to Clinical Governance Committee protocols to adopt	Project		In Progress	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 1d. Develop implementation plan for developing and training mobile crisis teams (based on environmental scan conducted of all crisis needs, services, and resources conducted)	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 1b .Hire or contract mobile crisis team staff	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 1d. Project Managers adopt or revises protocol based on local needs	Project		In Progress	06/30/2016	12/31/2017	12/31/2017	DY3 Q3
Task 1e. Clinical Governance Committee and Project Managers review and protocols at least annually	Project		In Progress	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task 1d. First responders (EMS, police, schools, etc.) are trained in mobile crisis protocols	Project		In Progress	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.	Project		In Progress	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 Primary Care Physicians	In Progress	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 Non-PCP Practitioners	In Progress	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 Hospitals	In Progress	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 Behavioral Health	In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.	Project		In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange	Project		In Progress	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Complete CNYCC partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Convene with project participants/providers to define alerting use cases to help support project activities.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 7. Work with applicable project partners and their respective vendors to implement connectivity strategy	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 8. Roll out QE access to participating partner organizations, including patient lookup services and identified alerting use cases	Project		In Progress	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Project	N/A	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. PPS compiles new and existing information on community and consumer need as well as the capacity of the central or decentralized triage services across the network so as to understand service related gaps, particularly for psychiatrists and behavioral health providers.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
2. PPS conducts gap analysis to understand where additional triage services are needed and establishes priorities with respect to these gaps							
Task 3. PPS explores options with respect to developing a centralized triage resource particularly for psychiatrists and behavioral health providers.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 4. Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Project	N/A	In Progress	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.	Project		In Progress	10/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.	Project		In Progress	10/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.	Project		In Progress	12/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.	Project		In Progress	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.	Project		In Progress	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify PIC sub-committee to serve as oversight and surveillance of compliance with protocols and quality of care (called 3aii QI Sub Committee)	Project		In Progress	04/01/2015	07/31/2015	09/30/2015	DY1 Q2
Task 2. Develop procedures for oversight and surveillance	Project		In Progress	04/01/2016	05/30/2016	06/30/2016	DY2 Q1
Task 3. Solicit CNYCC's Clinical Governance Committee approval for oversight and	Project		In Progress	06/01/2016	07/31/2016	09/30/2016	DY2 Q2

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
surveillance procedures							
Task 4. Initiate oversight and surveillance	Project		In Progress	08/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.	Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.	Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Identify core data elements needed for patient tracking requirements.	Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Complete gap analysis to compare required data to currently available data.	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.	Project		In Progress	09/01/2015	08/31/2016	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 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.										
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.										
Task 1. PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services										
Task 1a. Convene Project Implementation Collaborative										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 1b. PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.										
Task 1c. Crisis intervention program established in each of six counties										
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.										
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).										
Task 1. PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments)										
Task 1a. Current ED diversion protocols shared with PIC and RPAC members										
Task 1b. Assess literature for other evidence-based protocols related to ED diversion for patients in BH crisis										
Task 1c. Recommend to Clinical Governance Committee protocols to adopt										
Task 1d. Project Managers adopt or revises protocol based on local needs										
Task 1e. Clinical Governance Committee and Project Managers review and updates diversion management protocol at least annually										
Task 1f. First responders (EMS, police, schools, etc.) are trained in diversion protocols										
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.										
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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. PPS staff, along with PPS partners as appropriate, meet with selected Medicaid Managed Care (MCO) organizations to explore agreements or pilots between the PPS and or individual partners within the PPS										
Task 2. PPS staff, with partners and consultants as appropriate, conduct the necessary ground work required to establish sound VBP agreements between the MCOs and project 3aii partners, including work to understand service requirements, costs, impact of services on reducing MCO costs and inappropriate utilization, and payment										
Task 3. Based on initial discussions with MCOs and groundwork conducted, PPS staff and 3aii partners engage MCO in negotiating the details of a pilot program that would cover the services provided by the 3aii project										
Task 4. Assess impact of pilot and meet with MCO on periodic basis to perfect service requirements and core elements of VBP agreement so as to create the most appropriate inventive arrangements between the full breadth of appropriate clinical, social service, housing, and CBO partners,										
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.										
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.										
Task Coordinated treatment care protocols are in place.										
Task 1. Convene PICs										
Task 2a. Collect protocols in use by partners										
Task 2b. Review literature for evidence-based protocols related to project										
Task 2c. Recommend evidence-based protocols for review by CNYCC Clinical Governance Committee										
Task 2d. Disseminate evidence-based protocols to all participating partners										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 2e. Clinical Governance Committee and Project Managers review and updates treatment care protocol at least annually										
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.										
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network										
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	1	1	2	2	3	5	6	8
Task 1. PPS compiles new and existing information on community and consumer need as well as the capacity of the current network of specialty psychiatric and crisis- oriented psychiatric services throughout service area so as to understand service related gaps										
Task 2. PPS conducts gap analysis to understand where additional specialty psychiatric and crisis- oriented psychiatric services are needed and establishes priorities with respect to these gaps										
Task 3. PPS integrates work across its three mental, emotional, and behavioral health projects (3ai, 3aii, and 4aiii) so as to leverage resources and activities across projects										
Task 4. Based on information collected on need and capacity, the PPS includes at least one hospital with specialty psychiatric services and crisis- oriented										
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).										
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.										
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies	0	0	0	0	0	0	0	0	1	1

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
improvement areas, and implements improvement steps.										
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	2	2	2	4	4	4
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	0	0	0	0	3	3	3	6	6	6
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.										
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.										
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.										
Task 1a. Review operations, lessons learned, and protocols from current partner mobile crisis teams										
Task 1b. Assess literature for other evidence-based protocols for mobile crisis teams										
Task 1c. Recommend to Clinical Governance Committee protocols to adopt										
Task 1d. Develop implementation plan for developing and training mobile crisis teams (based on environmental scan conducted of all crisis needs, services, and resources conducted)										
Task 1b .Hire or contract mobile crisis team staff										
Task 1d. Project Managers adopt or revises protocol based on local needs										
Task 1e. Clinical Governance Committee and Project Managers review and protocols at least annually										
Task 1d. First responders (EMS, police, schools, etc.) are trained in										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
mobile crisis protocols										
Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	3	6	9	12	15	18
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	10	15	20	25	30	35
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	1	2	3	4	5	6
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	3	8	13	18	23	28
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.										
Task 1. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 2. Complete CNYCC partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 3. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange										
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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 5. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms										
Task 6. Convene with project participants/providers to define alerting use cases to help support project activities.										
Task 7. Work with applicable project partners and their respective vendors to implement connectivity strategy										
Task 8. Roll out QE access to participating partner organizations, including patient lookup services and identified alerting use cases										
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.										
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.										
Task 1. PPS compiles new and existing information on community and consumer need as well as the capacity of the central or decentralized triage services across the network so as to understand service related gaps, particularly for psychiatrists and behavioral health providers.										
Task 2. PPS conducts gap analysis to understand where additional triage services are needed and establishes priorities with respect to these gaps										
Task 3. PPS explores options with respect to developing a centralized triage resource particularly for psychiatrists and behavioral health providers.										
Task 4. Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.										
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.										
Task PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical 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
behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.										
Task PPS quality subcommittee conducts and/or reviews self-audits to ensure compliance with processes and procedures developed for this project.										
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.										
Task 1. Identify PIC sub-committee to serve as oversight and surveillance of compliance with protocols and quality of care (called 3aii QI Sub Committee)										
Task 2. Develop procedures for oversight and surveillance										
Task 3. Solicit CNYCC's Clinical Governance Committee approval for oversight and surveillance procedures										
Task 4. Initiate oversight and surveillance										
Milestone #11 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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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. Identify core data elements needed for patient tracking requirements.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										

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 a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.										
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.										
Task 1. PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services										
Task 1a. Convene Project Implementation Collaborative										
Task 1b. PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.										
Task 1c. Crisis intervention program established in each of six counties										
Milestone #2 Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.										
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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. PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments)										
Task 1a. Current ED diversion protocols shared with PIC and RPAC members										
Task 1b. Assess literature for other evidence-based protocols related to ED diversion for patients in BH crisis										
Task 1c. Recommend to Clinical Governance Committee protocols to adopt										
Task 1d. Project Managers adopt or revises protocol based on local needs										
Task 1e. Clinical Governance Committee and Project Managers review and updates diversion management protocol at least annually										
Task 1f. First responders (EMS, police, schools, etc.) are trained in diversion protocols										
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.										
Task PPS has engaged MCO in negotiating coverage of services under this project and/or MCO provides coverage for services in project.										
Task 1. PPS staff, along with PPS partners as appropriate, meet with selected Medicaid Managed Care (MCO) organizations to explore agreements or pilots between the PPS and or individual partners within the PPS										
Task 2. PPS staff, with partners and consultants as appropriate, conduct the necessary ground work required to establish sound VBP agreements between the MCOs and project 3aii partners, including work to understand service requirements, costs, impact of services on reducing MCO costs and inappropriate utilization, and payment										
Task 3. Based on initial discussions with MCOs and groundwork conducted, PPS staff and 3aii partners engage MCO in										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
negotiating the details of a pilot program that would cover the services provided by the 3aii project										
Task 4. Assess impact of pilot and meet with MCO on periodic basis to perfect service requirements and core elements of VBP agreement so as to create the most appropriate inventive arrangements between the full breadth of appropriate clinical, social service, housing, and CBO partners,										
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.										
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.										
Task Coordinated treatment care protocols are in place.										
Task 1. Convene PICs										
Task 2a. Collect protocols in use by partners										
Task 2b. Review literature for evidence-based protocols related to project										
Task 2c. Recommend evidence-based protocols for review by CNYCC Clinical Governance Committee										
Task 2d. Disseminate evidence-based protocols to all participating partners										
Task 2e. Clinical Governance Committee and Project Managers review and updates treatment care protocol at least annually										
Milestone #5 Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.										
Task PPS includes at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services in provider network										
Task PPS evaluates access to psychiatric services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	9	10	10	10	10	10	10	10	10	10

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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. PPS compiles new and existing information on community and consumer need as well as the capacity of the current network of specialty psychiatric and crisis- oriented psychiatric services throughout service area so as to understand service related gaps										
Task 2. PPS conducts gap analysis to understand where additional specialty psychiatric and crisis- oriented psychiatric services are needed and establishes priorities with respect to these gaps										
Task 3. PPS integrates work across its three mental, emotional, and behavioral health projects (3ai, 3aii, and 4aiii) so as to leverage resources and activities across projects										
Task 4. Based on information collected on need and capacity, the PPS includes at least one hospital with specialty psychiatric services and crisis- oriented										
Milestone #6 Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).										
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.										
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	2	10	10	10	10	10	10	10	10	10
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	4	28	28	28	28	28	28	28	28	28
Task PPS evaluates access to observation unit or off campus crisis residence services (in terms of community needs assessment, geographic access, wait times, and other measures), identifies improvement areas, and implements improvement steps.	6	39	39	39	39	39	39	39	39	39
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.										

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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 includes mobile crisis teams to help meet crisis stabilization needs of the community.										
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.										
Task 1a. Review operations, lessons learned, and protocols from current partner mobile crisis teams										
Task 1b. Assess literature for other evidence-based protocols for mobile crisis teams										
Task 1c. Recommend to Clinical Governance Committee protocols to adopt										
Task 1d. Develop implementation plan for developing and training mobile crisis teams (based on environmental scan conducted of all crisis needs, services, and resources conducted)										
Task 1b .Hire or contract mobile crisis team staff										
Task 1d. Project Managers adopt or revises protocol based on local needs										
Task 1e. Clinical Governance Committee and Project Managers review and protocols at least annually										
Task 1d. First responders (EMS, police, schools, etc.) are trained in mobile crisis protocols										
Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	21	26	26	26	26	26	26	26	26	26
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	40	138	138	138	138	138	138	138	138	138

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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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	7	10	10	10	10	10	10	10	10	10
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	33	39	39	39	39	39	39	39	39	39
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.										
Task 1. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 2. Complete CNYCC partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 3. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange										
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task 5. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms										
Task 6. Convene with project participants/providers to define alerting use cases to help support project activities.										
Task 7. Work with applicable project partners and their respective vendors to implement connectivity strategy										
Task 8. Roll out QE access to participating partner organizations, including patient lookup services and identified alerting use cases										
Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, 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
substance abuse providers.										
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.										
Task 1. PPS compiles new and existing information on community and consumer need as well as the capacity of the central or decentralized triage services across the network so as to understand service related gaps, particularly for psychiatrists and behavioral health providers.										
Task 2. PPS conducts gap analysis to understand where additional triage services are needed and establishes priorities with respect to these gaps										
Task 3. PPS explores options with respect to developing a centralized triage resource particularly for psychiatrists and behavioral health providers.										
Task 4. Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.										
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.										
Task PPS has created an active quality subcommittee that reports to PPS quality committee that is representative of medical and behavioral health staff and is specifically focused on integration of primary care and behavioral health services within practice sites and other behavioral health project initiatives. Note: Only one quality sub-committee is required for medical and behavioral health integration projects in Domain 3a.										
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement methodologies, develops implementation plans, and evaluates results of quality improvement initiatives.										
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Behavioral Health Metrics.										
Task PPS quality subcommittee conducts and/or reviews self-audits										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
to ensure compliance with processes and procedures developed for this project.										
Task Service and quality outcome measures are reported to all stakeholders including PPS quality committee.										
Task 1. Identify PIC sub-committee to serve as oversight and surveillance of compliance with protocols and quality of care (called 3aii QI Sub Committee)										
Task 2. Develop procedures for oversight and surveillance										
Task 3. Solicit CNYCC's Clinical Governance Committee approval for oversight and surveillance procedures										
Task 4. Initiate oversight and surveillance										
Milestone #11 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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	
Establish clear linkages with Health Homes, ER and hospital services to develop and implement protocols for diversion of patients from emergency room and inpatient services.	
Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	
Develop written treatment protocols with consensus from participating providers and facilities.	
Include at least one hospital with specialty psychiatric services and crisis-oriented psychiatric services; expansion of access to specialty psychiatric and crisis-oriented services.	
Expand access to observation unit within hospital outpatient or at an off campus crisis residence for stabilization monitoring services (up to 48 hours).	
Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	
Ensure that all PPS safety net providers have actively connected EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up by the end of Demonstration Year (DY) 3.	

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Central New York Care Collaborative, Inc. (PPS ID:8)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	
Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	
Use EHRs or other technical platforms to track all patients engaged in this project.	

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IPQR Module 3.a.ii.5 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 3.a.ii.6 - IA Monitoring

Instructions :

Milestone 3: PPS needs to include specific steps toward completion of the milestone.
Milestone 5: PPS needs to include specific steps toward completion of the milestone.
Milestone 9: PPS needs to include specific steps toward completion of the milestone.

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Central New York Care Collaborative, Inc. (PPS ID:8)

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.

1. Risk: Primary care providers are a critical partner for this project. They are reporting the activated patient and will be a critical part of the team of providers who will help patients develop a care management plan. A risk is that CNYCC does not engage enough primary care providers to complete the project work. Potential Impact: If primary care providers do not participate in the project, these complex patients risk moving forward without a care management plan. This means that CNYCC will not meet patient activation numbers, and further that the patients' health will fail to improve. Mitigation: In the short term, CNYCC will outreach specifically to PCPs who have yet to attest to the project to encourage them to join the Project Implementation Collaborative. Additionally, CNYCC will increase efforts to educate primary care providers on the alignment of 3.b.i project activities with PCMH implementation. CNYCC sees strong alignment between these initiatives, and communicating this may allay some hesitations of PCPs that participation in the project will cause significant added burden.

2. Risk: Advances are needed in creating social and physical environments that support healthy individual behaviors. Yet, people who think about behaviors like diet and physical activity as solely an individual issue are less likely to support policies aimed at changing the environment (e.g., school, community, and industry regulations). Potential Impact: Without public and partner support for a social perspective on health promotion, efforts will continue to be focused on individuals and not communities. This narrow perspective will limit the potential impact of health promotion efforts. Increasing access to opportunities to eat healthier (e.g., ensuring quality, affordable fruits and vegetables are easily accessible and low-sodium menu items are available in restaurants) and be physically active (e.g., increasing number of days children have physical education class in schools) will help to prevent and treat cardiovascular disease by creating an environment that supports healthy behaviors. This has potential for great impact, especially in less affluent communities where environmental supports for healthy behaviors are lacking. Mitigation: Healthcare providers are well respected and trusted in the community and can advocate for things like availability of resources to meet daily needs (e.g., safe housing and local food markets), availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities, transportation options, and public safety. Making these advances involves working together to: explore how programs, practices, and policies in these areas affect the health of individuals, families, and communities. There is a need to establish common goals, complementary roles, and ongoing constructive relationships between the health sector and these areas. Moreover, public health professionals and clinical providers can, and should share, health-related data with non-public health partners to increase support and buy-in.

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Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 3.b.i.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	217	0	0	0	0	0	0	0	43	86	130
Non-PCP Practitioners	538	0	0	0	0	0	0	0	108	216	324
Clinics	24	0	0	0	0	0	0	0	5	10	15
Health Home / Care Management	8	0	0	0	0	0	0	0	0	2	4
Behavioral Health	36	0	0	0	0	0	0	0	7	14	21
Substance Abuse	5	0	0	0	0	0	0	0	1	2	3
Pharmacies	6	0	0	0	0	0	0	0	1	2	3
Community Based Organizations	6	0	0	0	0	0	0	0	1	2	3
All Other	452	0	0	0	0	0	0	0	90	180	270
Total Committed Providers	**1,292**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**256**	**514**	**773**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**19.81**	**39.78**	**59.83**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	217	172	217	217	217	217	217	217	217	217	217
Non-PCP Practitioners	538	432	538	538	538	538	538	538	538	538	538
Clinics	24	20	24	24	24	24	24	24	24	24	24
Health Home / Care Management	8	6	8	8	8	8	8	8	8	8	8
Behavioral Health	36	28	36	36	36	36	36	36	36	36	36

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Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Substance Abuse	5	4	5	5	5	5	5	5	5	5	5
Pharmacies	6	4	6	6	6	6	6	6	6	6	6
Community Based Organizations	6	4	6	6	6	6	6	6	6	6	6
All Other	452	360	452	452	452	452	452	452	452	452	452
Total Committed Providers	**1,292**	**1,030**	**1,292**	**1,292**	**1,292**	**1,292**	**1,292**	**1,292**	**1,292**	**1,292**	**1,292**
Percent Committed Providers(%)		**79.72**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Project requirement 1, "Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting" will not be met until DY3Q4. Since that requirement is assigned to the project unit level, no individual providers can meet all of the project requirements (as set out in the project Plan Application) until that date. We believe this project requirement represents the "rate limiting" requirement for Project 3bi because CNYCC will need 80% of all PCPs in the PPS to meet this requirement. Given the complexity of many of the project's deliverables, it is likely that there will be a drawn out, incremental roll-out of this project. We anticipate that there will be late adopters that will struggle to meet all of project's requirements and will not fully implement this project until late in DY3. The CNYCC further expects that it will need to reach out to and engage many practices and entice them to participate so that we can achieve the 80% threshold.

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Central New York Care Collaborative, Inc. (PPS ID:8)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	26,800

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	300	1,850	3,400	5,100	6,800	3,400	6,800
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**1.12**	**6.90**	**12.69**	**19.03**	**25.37**	**12.69**	**25.37**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	10,100	13,400	6,800	13,400	20,100	26,800	6,800	13,400	20,100	26,800
Percent of Expected Patient Engagement(%)	**37.69**	**50.00**	**25.37**	**50.00**	**75.00**	**100.00**	**25.37**	**50.00**	**75.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	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	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project		In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Convene Project Implementation Collaborative (PIC)	Project		Completed	06/15/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Conduct a systematic review and environmental scan of participating partners/providers' practices regarding CVD	Project		In Progress	09/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task 3. Conduct a review of community CVD needs, resources, and service/system gaps	Project		In Progress	09/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task 4. Review literature and identify evidence based strategies for best practices	Project		In Progress	09/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task 5. Compare current organizational practices with best practice and adopt evidence-based protocols	Project		In Progress	12/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Educate health care providers and administrators about the importance/benefit of systematic approaches and/or organizational changes needed to enhance population health	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Identify strategic priorities endorsed by providers and administrators	Project		In Progress	01/01/2016	01/31/2016	03/31/2016	DY1 Q4
Task 8. Develop a strategic improvement and monitoring plan and implement	Project		In Progress	01/01/2016	01/31/2016	03/31/2016	DY1 Q4
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure	Project	N/A	In Progress	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	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
messaging), alerts and patient record look up, by the end of DY 3.							
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Primary Care Physicians	In Progress	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 Non-PCP Practitioners	In Progress	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 Behavioral Health	In Progress	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	03/31/2018	DY3 Q4
Task 1. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange	Project		In Progress	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Complete CNYCC partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms	Project		In Progress	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Convene with project participants/providers to define alerting use cases to help support project activities.	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 7. Work with applicable project partners and their respective vendors to implement connectivity strategy	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 8. Roll out QE access to participating partner organizations, including patient lookup services and identified alerting use cases	Project		In Progress	04/01/2015	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	Project	N/A	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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).	Project		In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Primary Care Physicians	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify all participating safety net primary care practices and associated providers	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 3.a) Define Meaningful Use Stage 2 requirements and align/incorporate cardiovascular disease management strategies with those requirements.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate cardiovascular disease management strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.	Project		In Progress	08/04/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.	Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice.	Project		In Progress	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 11. Participating providers successfully complete MU Stage 2 attestation.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.	Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.	Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Identify core data elements needed for patient tracking requirements as well as care cardiovascular disease management and identify the expected sources of data.	Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Complete gap analysis to compare required data to currently available data.	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task 7. Finalize definition for actively engaged patients to be used by participating CNYCC partners.	Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 8. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.	Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1

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Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff to incorporate the use of EHR to prompt the use of 5 A's of tobacco control.	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Work with Public Health staff and partner organizations to conduct trainings (i.e. in person, train the trainer, etc.) on 1) the 5A model, including the value in linking patients to community organizations, 2) motivational interviewing, 3) cultural competency, and 4) tobacco treatment resources	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Create an inventory of linguistically appropriate tobacco treatment resources (local, regional and statewide) and work towards a bi-lateral referral process among health care and community-based organizations	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Work with project partners and their respective EHR vendors to assess their capability to support workflow automation	Project		In Progress	11/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 4. Develop 5A's script and workflow for brief intervention to be offered by providers if patient tobacco use is identified	Project		In Progress	11/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 5. Train providers (via written materials, in-person meetings, or training the trainer approaches) how to input consistent information (for example tobacco use diagnosis, billing codes and patient referral response) into the EHR	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. In collaboration with Public Health Department, develop and disseminate brochures, PowerPoint slides, and job aids to implement the 5A's (including a chart that explains insurance coverage, pharmacotherapy and dosing guide, and which reinforces combination therapy)	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Provide ongoing technical assistance on tobacco treatment, motivational interviewing, cultural competency, and resources to clinic staff	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Work with partners and their respective EMR vendors to implement automated workflow for identified interventions and required prompts	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Project	N/A	In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 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		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify and institutionalize a standardized hypertension protocol through the 3bi PIC. The PIC will draw from its literature review of best/prove practices to develop the standardized protocol and then will conduct trainings ((i.e. in person, train the trainer, etc.) to standardized protocol in a participating practices	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Designate hypertension champions within organization	Project		In Progress	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Create an inventory of linguistically appropriate hypertension and cholesterol treatment resources (local, regional and statewide) and work towards a referral process among health care and community based organizations	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Work with Public Health staff and other partner organizations to provide trainings (i.e. in person, train the trainer, etc.) on 1) current screening and treatment protocols for hypertension and elevated cholesterol, 2) motivational interviewing, 3) cultural competency, 4) treatment value in linking patients to community organizations/resources	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 5. Develop motivational interviewing script and work flow for brief intervention to be offered by providers if risk factors are identified	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Train providers (via written materials, in-person meetings, or training the trainer approaches) on how to input consistent information on risk factors and test results into the EHR	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. In collaboration with Public Health Department and other health and community organizations, develop and disseminate brochures, PowerPoint slides, and job aids to implement the hypertension and high cholesterol prevention and treatment protocols (including a chart that explains insurance coverage, medication and dosing guide)	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
8. Provide ongoing technical assistance on hypertension and high cholesterol treatment, motivational interviewing, cultural competency, and resources to clinical and other staff as appropriate							
Task 9. Work with partners and their respective EMR vendors to implement automated workflow for identified interventions and required prompts	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 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	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify financing and care coordination tools (e g , Care Coordination Measures Atlas, developed by the Agency for Healthcare Research and Quality) and codes which allow physicians to document and bill for coordinating care between community service agencies, linking patients to resources, supporting the transition of patients from inpatient to other settings, and working to limit preventable readmissions	Project		In Progress	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Develop and institutionalize a care coordination team model that outlines multidisciplinary member roles and responsibilities and is centered on the comprehensive needs of the patient and family, leading to decreased health care costs, reduction in fragmented care, and improvement in the patient/family experience of care	Project		In Progress	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Using identified tools, increase awareness among multi-disciplinary health care and community workers about the benefits of care coordination	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Work with project partners and their respective EHR vendors to assess their capability to document patients' lifestyle behaviors and medication adherence according to the care coordination model and which considers health literacy	Project		In Progress	11/01/2015	04/30/2016	06/30/2016	DY2 Q1

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issues, patient self-efficacy							
Task 5. Develop and institutionalize a mobile care coordination team to travel to high-risk/need areas (or a system for transporting high-risk patients to the care coordination team)	Project		In Progress	02/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 6. Train care coordination team (i.e. in person, train the trainer, etc.) in the development of a culturally appropriate coordinated care plan to be used across the continuum of care by medical, educational, mental health, community, and home care provider	Project		In Progress	03/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Develop monitoring plan for ensuring effective coordinated care and patient plans	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 8. Work with partners and their respective EMR vendors to implement care coordination documentation requirements	Project		In Progress	01/01/2016	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	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Provider	Primary Care Physicians	In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify and promote existing health care facilities and community-based organizations/events which have properly maintained blood pressure monitors and walk-in clinics	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 2. Develop and institutionalize a mobile health van to travel to high-risk/high-need areas (places where high-risk people may congregate such as WIC clinics, refugee resettlement agencies, social service settings, etc.)	Project		In Progress	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Develop and disseminate materials/digital communications that guide patients in the use of home-based blood pressure devices and availability of drop-in blood pressure readings	Project		In Progress	02/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Train (i.e. in person, train the trainer, etc.) clerical personnel in proper blood pressure measurement technique so they are capable of obtaining drop-in blood pressure readings	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9	Project	N/A	In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop an evidence-based protocol for training staff on blood pressure measurement and equipment maintenance	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Conduct annual mandatory trainings to all new and existing staff involved in measuring and recording blood pressure to ensure competency	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Designate champions within the organizations	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Develop a tracking system for monitoring training and proficiency	Project		In Progress	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Project	N/A	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Convene with project participants/providers to inventory criteria that would be required for the identification, risk stratification, and engagement of patients for the project	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Finalize risk stratification requirements, including inclusion/exclusion criteria, metric definitions, clinical value thresholds and risk scoring algorithm.	Project		In Progress	01/01/2016	02/28/2016	03/31/2016	DY1 Q4
Task 3. Develop motivational interviewing script and work flow for brief intervention to be offered by providers if repeated elevated blood pressure readings are identified and patient is scheduled for hypertension visit	Project		In Progress	01/01/2016	02/28/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 4. Identify core data elements needed for risk stratification requirements.	Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 5. Work with project partners and their respective EHR vendors to assess their capability to support workflow automation to facilitate scheduling of target patient population	Project		In Progress	11/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 6. Complete gap analysis to compare required data to currently available data.	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 7. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 8. Work with participating partners and their EMR vendors to identify local risk stratification capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task 9. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task 10. Finalize required functionality and select a PHM software vendor	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task 11. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning) and obtain board approval.	Project		In Progress	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task 12. Work with partners and their respective EMR vendors to implement automated workflow for appointment scheduling	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 13. Implement PHM roadmap	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Project	N/A	In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify and institutionalize a standardized hypertension protocol	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Task 2. Designate hypertension champions within organization	Project		In Progress	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Prescribe once-daily regimens or fixed-dose combination pills when appropriate	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Self-management goals are documented in the clinical record.	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task 1. Provide trainings (i.e. in person, train the trainer, etc.) on 1) the value of patient driven self-management goals in the medical record 2) motivational interviewing, and 3) cultural competency	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Work with project partners and their respective EHR vendors to assess their capability to document patients' self-management goals	Project		In Progress	01/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task 3. Develop scripts and workflow for review of self-management goals to be used by providers at each visit	Project		In Progress	01/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task 4. Train providers how to input consistent self-management goals into the medical record	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Provide ongoing technical assistance on patient driven self-management goals in the medical record to clinic staff	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Work with partners and their respective EMR vendors to implement care coordination documentation requirements	Project		In Progress	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Project	N/A	In Progress	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	11/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Project		In Progress	11/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.							
Task 1. Provide trainings (i.e. in person, train the trainer, etc.) on 1) the value of patient driven self-management goals in the medical record 2) motivational interviewing, and 3) cultural competency	Project		In Progress	11/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Contact community based organizations and engage administration in planning for referral systems Develop MOU's regarding referral workflows and how to address referral issues/problems Establish Business Associate Agreements (BAA), which adhere to HIPAA requirements	Project		In Progress	12/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. To the degree possible establish mechanisms for community based organizations to report back client status changes in a manner that upholds HIPAA requirements	Project		In Progress	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Create and systematize a referral mechanism to each health and community based organization involved, which meets their referral criteria and format Include verbal referral or warmline transfer, paper fax or direct EMR referrals	Project		In Progress	12/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Project	N/A	In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Create an inventory of protocols and identify most appropriate ones for target population	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Provide trainings on the value of home blood pressure monitoring	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Provide blood pressure monitoring training to patients	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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4. Assign appropriate person to conduct follow ups							
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	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Establish criteria for selecting patients with hypertension in need of follow-up visits	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking follow-up.	Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Work with project partners and their respective EHR vendors to assess their capability to support workflow automation to facilitate scheduling of target patient population identified in reports.	Project		In Progress	11/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 4. Run an analysis of prior visit dates against list of patients with hypertension and identify those in need of a follow up appointment	Project		In Progress	01/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task 5. Work with partners and their respective EMR vendors to implement care coordination documentation requirements	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Train ((i.e. in person, train the trainer, etc.) providers in understanding the efficacy of and services provided by the NYS Smoker's Quitline Services Reinforce the 5A's so that providers a) identify tobacco users at every patient encounter, b) intervene with each tobacco user and c) refer to the Quitline	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Utilize the comprehensive training and guidance materials that are available on the NYS Smokers' Quitline website	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 3. Implement 5A's script and workflow for brief intervention to be offered by providers if patient tobacco use is identified	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
4. Implement an EMR system that has the capacity to make on the spot NYS Smokers' Quitline referrals through their secure on-line referral or fax referral system							
Task 5. Create a mechanism for NYS Smokers' Quitline progress report to be added to the patient record once received	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Project	N/A	In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	09/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Convene with project participants/providers to inventory criteria that would be required for the identification, risk stratification, and engagement of patients for the project	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Finalize risk stratification requirements, including inclusion/exclusion criteria, metric definitions, clinical value thresholds and risk scoring algorithm.	Project		In Progress	01/01/2016	02/28/2016	03/31/2016	DY1 Q4
Task 3. Identify and train individuals with at least one chronic condition to facilitate chronic disease self-management workshops in community settings such as senior centers, churches, libraries, clinics, and hospitals	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Schedule workshops in high-risk neighborhoods	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 5. Provide trainings on Stanford Model for chronic diseases including the value in linking patients to community organizations/resources to healthcare providers	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 6. Identify core data elements needed for risk stratification requirements.	Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 7. Complete gap analysis to compare required data to currently available data.	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 8. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 9. Work with participating partners and their EMR vendors to identify local risk stratification capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Milestone #18 Adopt strategies from the Million Hearts Campaign.	Project	N/A	In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Primary Care Physicians	In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Non-PCP Practitioners	In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Behavioral Health	In Progress	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify local and regional contacts and linkages who have participated in the Million Hearts Campaign planning, implementation and evaluation activities	Project		In Progress	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 2. Develop an inclusive and multi-disciplinary leadership group made up of health care institutions, community based organizations and individual stakeholders	Project		Completed	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Join the Guiding Coalition by signing up on-line to access resources and get involved	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Review Million Hearts Campaign report and identify asset based core strategies implemented through workgroups	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Register for and participate in scheduled member connection calls/webinars	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Establish hypertension and high level cholesterol work groups to develop an implementation plan for each of the six core strategies, which focus on	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3

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improving health care systems through community collaboration and partnership and sustainable business models co-designed with people who the health care systems are designed to serve							
Task 7. Strategy: Identify and use data to ascertain problem areas	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 8. Strategy: Identify interventions with the highest probability of decreasing harm, mortality, or readmission rates Ensure strategies are appropriate for intended short, intermediate and long term outcomes	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 9. Strategy: Start in areas that are likely to show early success	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 10. Develop monitoring plan for ensuring implementation of strategies	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 11. Evaluate progress at regular intervals and identify areas needing revision/adjustment	Project		In Progress	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
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	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Project		In Progress	12/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Investigate MCOs serving affected populations to assess its market share, service area, stability, solvency, and reputation	Project		In Progress	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Identify the most relevant MCOs to form agreements with by considering the answers to the following questions: Is the MCO actuarially sound? Does it have a good reputation among patients and other providers? Is the plan coverage booklet clear and comprehensive? Do enrollees switch frequently from one primary care physician to another? What is the role of the primary care physician? Does it pay providers on time in accordance with its contractual obligations?	Project		In Progress	12/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Determine and finalize the conditions of the agreement including service coordination	Project		In Progress	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #20	Project	N/A	In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Provider	Primary Care Physicians	In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. PPS will inventory the number of primary care practices that have attested to this project and compare it to the list of adult primary care practices that are part of the PPS' network	Project		In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. PPS will identify the primary care practices that have not engaged in this project and develop a multi-pronged action plan to promote engagement and participation of practices in this project	Project		In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. PPS Staff and consultants as appropriate will engage practices in a series of training and technical assistance activities to ensure that primary care practices are provided the support they need to adopt the broad range of practices, protocols, and processes that are part of the Millions Heart Initiative. (The body of evidence and experience suggests that simply distributing the protocols and policies to practices will not lead to broad, far reaching change.)	Project		In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. PPS will assess participation rates on a regular basis and continue to implement its action plan until the PPS achieves the 80% threshold	Project		In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.										
Task 1. Convene Project Implementation Collaborative (PIC)										
Task 2. Conduct a systematic review and environmental scan of participating partners/providers' practices regarding CVD										
Task 3. Conduct a review of community CVD needs, resources, 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
service/system gaps										
Task 4. Review literature and identify evidence based strategies for best practices										
Task 5. Compare current organizational practices with best practice and adopt evidence-based protocols										
Task 6. Educate health care providers and administrators about the importance/benefit of systematic approaches and/or organizational changes needed to enhance population health										
Task 7. Identify strategic priorities endorsed by providers and administrators										
Task 8. Develop a strategic improvement and monitoring plan and implement										
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	5	10	15	20	26	32
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	10	25	40	55	80	100
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	2	4	6	8	12	16
Task PPS uses alerts and secure messaging functionality.										
Task 1. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 2. Complete CNYCC partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 3. Prioritize partners/vendor engagements with top priority 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
those currently capable and willing to participate in standards compliant exchange										
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task 5. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms										
Task 6. Convene with project participants/providers to define alerting use cases to help support project activities.										
Task 7. Work with applicable project partners and their respective vendors to implement connectivity strategy										
Task 8. Roll out QE access to participating partner organizations, including patient lookup services and identified alerting use cases										
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	4	8	8	30	93	97
Task 1. Identify all participating safety net primary care practices and associated providers										
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 3.a) Define Meaningful Use Stage 2 requirements and align/incorporate cardiovascular disease management strategies with those requirements.										
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements 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
integrate cardiovascular disease management strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project										

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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
participation.										
Task 3. Identify core data elements needed for patient tracking requirements as well as care cardiovascular disease management and identify the expected sources of data.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										
Task 7. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 8. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
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. Work with Public Health staff and partner organizations to conduct trainings (i.e. in person, train the trainer, etc.) on 1) the 5A model, including the value in linking patients to community organizations, 2) motivational interviewing, 3) cultural competency, and 4) tobacco treatment resources										
Task 2. Create an inventory of linguistically appropriate tobacco treatment resources (local, regional and statewide) and work towards a bi-lateral referral process among health care and community-based organizations										

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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. Work with project partners and their respective EHR vendors to assess their capability to support workflow automation										
Task 4. Develop 5A's script and workflow for brief intervention to be offered by providers if patient tobacco use is identified										
Task 5. Train providers (via written materials, in-person meetings, or training the trainer approaches) how to input consistent information (for example tobacco use diagnosis, billing codes and patient referral response) into the EHR										
Task 6. In collaboration with Public Health Department, develop and disseminate brochures, PowerPoint slides, and job aids to implement the 5A's (including a chart that explains insurance coverage, pharmacotherapy and dosing guide, and which reinforces combination therapy)										
Task 7. Provide ongoing technical assistance on tobacco treatment, motivational interviewing, cultural competency, and resources to clinic staff										
Task 8. Work with partners and their respective EMR vendors to implement automated workflow for identified interventions and required prompts										
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. Identify and institutionalize a standardized hypertension protocol through the 3bi PIC. The PIC will draw from its literature review of best/prove practices to develop the standardized protocol and then will conduct trainings ((i.e. in person, train the trainer, etc.) to standardized protocol in a participating practices										
Task 2. Designate hypertension champions within organization										
Task 3. Create an inventory of linguistically appropriate hypertension and cholesterol treatment resources (local, regional 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
statewide) and work towards a referral process among health care and community based organizations										
Task 4. Work with Public Health staff and other partner organizations to provide trainings (i.e. in person, train the trainer, etc.) on 1) current screening and treatment protocols for hypertension and elevated cholesterol, 2) motivational interviewing, 3) cultural competency, 4) treatment value in linking patients to community organizations/resources										
Task 5. Develop motivational interviewing script and work flow for brief intervention to be offered by providers if risk factors are identified										
Task 6. Train providers (via written materials, in-person meetings, or training the trainer approaches) on how to input consistent information on risk factors and test results into the EHR										
Task 7. In collaboration with Public Health Department and other health and community organizations, develop and disseminate brochures, PowerPoint slides, and job aids to implement the hypertension and high cholesterol prevention and treatment protocols (including a chart that explains insurance coverage, medication and dosing guide)										
Task 8. Provide ongoing technical assistance on hypertension and high cholesterol treatment, motivational interviewing, cultural competency, and resources to clinical and other staff as appropriate										
Task 9. Work with partners and their respective EMR vendors to implement automated workflow for identified interventions and required prompts										
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										

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Home care managers where applicable.										
Task Care coordination processes are in place.										
Task 1. Identify financing and care coordination tools (e g , Care Coordination Measures Atlas, developed by the Agency for Healthcare Research and Quality) and codes which allow physicians to document and bill for coordinating care between community service agencies, linking patients to resources, supporting the transition of patients from inpatient to other settings, and working to limit preventable readmissions										
Task 2. Develop and institutionalize a care coordination team model that outlines multidisciplinary member roles and responsibilities and is centered on the comprehensive needs of the patient and family, leading to decreased health care costs, reduction in fragmented care, and improvement in the patient/family experience of care										
Task 3. Using identified tools, increase awareness among multi-disciplinary health care and community workers about the benefits of care coordination										
Task 4. Work with project partners and their respective EHR vendors to assess their capability to document patients' lifestyle behaviors and medication adherence according to the care coordination model and which considers health literacy issues, patient self-efficacy										
Task 5. Develop and institutionalize a mobile care coordination team to travel to high-risk/need areas (or a system for transporting high-risk patients to the care coordination team)										
Task 6. Train care coordination team (i.e. in person, train the trainer, etc.) in the development of a culturally appropriate coordinated care plan to be used across the continuum of care by medical, educational, mental health, community, and home care provider										
Task 7. Develop monitoring plan for ensuring effective coordinated care and patient plans										
Task 8. Work with partners and their respective EMR vendors to implement care coordination documentation requirements										
Milestone #8										

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Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	0	0	0	0	0	0	0	50	100	150
Task 1. Identify and promote existing health care facilities and community-based organizations/events which have properly maintained blood pressure monitors and walk-in clinics										
Task 2. Develop and institutionalize a mobile health van to travel to high-risk/high-need areas (places where high-risk people may congregate such as WIC clinics, refugee resettlement agencies, social service settings, etc.)										
Task 3. Develop and disseminate materials/digital communications that guide patients in the use of home-based blood pressure devices and availability of drop-in blood pressure readings										
Task 4. Train (i.e. in person, train the trainer, etc.) clerical personnel in proper blood pressure measurement technique so they are capable of obtaining drop-in blood pressure readings										
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.										
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.										
Task 1. Develop an evidence-based protocol for training staff on blood pressure measurement and equipment maintenance										
Task 2. Conduct annual mandatory trainings to all new and existing staff involved in measuring and recording blood pressure to ensure competency										
Task 3. Designate champions within the organizations										
Task 4. Develop a tracking system for monitoring training and proficiency										
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.										

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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 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. Convene with project participants/providers to inventory criteria that would be required for the identification, risk stratification, and engagement of patients for the project										
Task 2. Finalize risk stratification requirements, including inclusion/exclusion criteria, metric definitions, clinical value thresholds and risk scoring algorithm.										
Task 3. Develop motivational interviewing script and work flow for brief intervention to be offered by providers if repeated elevated blood pressure readings are identified and patient is scheduled for hypertension visit										
Task 4. Identify core data elements needed for risk stratification requirements.										
Task 5. Work with project partners and their respective EHR vendors to assess their capability to support workflow automation to facilitate scheduling of target patient population										
Task 6. Complete gap analysis to compare required data to currently available data.										
Task 7. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 8. Work with participating partners and their EMR vendors to identify local risk stratification capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
Task 9. Complete inventory of HIT-related PHM deliverables 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
current use cases to support project requirements										
Task 10. Finalize required functionality and select a PHM software vendor										
Task 11. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning) and obtain board approval.										
Task 12. Work with partners and their respective EMR vendors to implement automated workflow for appointment scheduling										
Task 13. Implement PHM roadmap										
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. Identify and institutionalize a standardized hypertension protocol										
Task 2. Designate hypertension champions within organization										
Task 3. Prescribe once-daily regimens or fixed-dose combination pills when appropriate										
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. Provide trainings (i.e. in person, train the trainer, etc.) on 1) the value of patient driven self-management goals in the medical record 2) motivational interviewing, and 3) cultural competency										
Task 2. Work with project partners and their respective EHR vendors										

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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 assess their capability to document patients' self-management goals										
Task 3. Develop scripts and workflow for review of self-management goals to be used by providers at each visit										
Task 4. Train providers how to input consistent self-management goals into the medical record										
Task 5. Provide ongoing technical assistance on patient driven self-management goals in the medical record to clinic staff										
Task 9. Work with partners and their respective EMR vendors to implement care coordination documentation requirements										
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. Provide trainings (i.e. in person, train the trainer, etc.) on 1) the value of patient driven self-management goals in the medical record 2) motivational interviewing, and 3) cultural competency										
Task 2. Contact community based organizations and engage administration in planning for referral systems Develop MOU's regarding referral workflows and how to address referral issues/problems Establish Business Associate Agreements (BAA), which adhere to HIPAA requirements										
Task 3. To the degree possible establish mechanisms for community based organizations to report back client status changes in a manner that upholds HIPAA requirements										
Task 4. Create and systematize a referral mechanism to each health										

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and community based organization involved, which meets their referral criteria and format Include verbal referral or warmline transfer, paper fax or direct EMR referrals										
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.										
Task PPS has developed and implemented protocols for home blood pressure monitoring.										
Task PPS provides follow up to support to patients with ongoing blood pressure monitoring, including equipment evaluation and follow-up if blood pressure results are abnormal.										
Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task 1. Create an inventory of protocols and identify most appropriate ones for target population										
Task 2. Provide trainings on the value of home blood pressure monitoring										
Task 3. Provide blood pressure monitoring training to patients										
Task 4. Assign appropriate person to conduct follow ups										
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 criteria for selecting patients with hypertension in need of follow-up visits										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking follow-up.										
Task 3. Work with project partners and their respective EHR vendors to assess their capability to support workflow automation to facilitate scheduling of target patient population identified in reports.										

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Task 4. Run an analysis of prior visit dates against list of patients with hypertension and identify those in need of a follow up appointment										
Task 5. Work with partners and their respective EMR vendors to implement care coordination documentation requirements										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task 1. Train ((i.e. in person, train the trainer, etc.) providers in understanding the efficacy of and services provided by the NYS Smoker's Quitline Services Reinforce the 5A's so that providers a) identify tobacco users at every patient encounter, b) intervene with each tobacco user and c) refer to the Quitline										
Task 2. Utilize the comprehensive training and guidance materials that are available on the NYS Smokers' Quitline website										
Task 3. Implement 5A's script and workflow for brief intervention to be offered by providers if patient tobacco use is identified										
Task 4. Implement an EMR system that has the capacity to make on the spot NYS Smokers' Quitline referrals through their secure on-line referral or fax referral system										
Task 5. Create a mechanism for NYS Smokers' Quitline progress report to be added to the patient record once received										
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.										

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Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.										
Task 1. Convene with project participants/providers to inventory criteria that would be required for the identification, risk stratification, and engagement of patients for the project										
Task 2. Finalize risk stratification requirements, including inclusion/exclusion criteria, metric definitions, clinical value thresholds and risk scoring algorithm.										
Task 3. Identify and train individuals with at least one chronic condition to facilitate chronic disease self-management workshops in community settings such as senior centers, churches, libraries, clinics, and hospitals										
Task 4. Schedule workshops in high-risk neighborhoods										
Task 5. Provide trainings on Stanford Model for chronic diseases including the value in linking patients to community organizations/resources to healthcare providers										
Task 6. Identify core data elements needed for risk stratification requirements.										
Task 7. Complete gap analysis to compare required data to currently available data.										
Task 8. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 9. Work with participating partners and their EMR vendors to identify local risk stratification capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	50	100	217	217	217

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Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	0	250	538	538	538
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	10	20	36	36	36
Task 1. Identify local and regional contacts and linkages who have participated in the Million Hearts Campaign planning, implementation and evaluation activities										
Task 2. Develop an inclusive and multi-disciplinary leadership group made up of health care institutions, community based organizations and individual stakeholders										
Task 3. Join the Guiding Coalition by signing up on-line to access resources and get involved										
Task 4. Review Million Hearts Campaign report and identify asset based core strategies implemented through workgroups										
Task 5. Register for and participate in scheduled member connection calls/webinars										
Task 6. Establish hypertension and high level cholesterol work groups to develop an implementation plan for each of the six core strategies, which focus on improving health care systems through community collaboration and partnership and sustainable business models co-designed with people who the health care systems are designed to serve										
Task 7. Strategy: Identify and use data to ascertain problem areas										
Task 8. Strategy: Identify interventions with the highest probability of decreasing harm, mortality, or readmission rates Ensure strategies are appropriate for intended short, intermediate and long term outcomes										
Task 9. Strategy: Start in areas that are likely to show early success										
Task 10. Develop monitoring plan for ensuring implementation of strategies										

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Task 11. Evaluate progress at regular intervals and identify areas needing revision/adjustment										
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. Investigate MCOs serving affected populations to assess its market share, service area, stability, solvency, and reputation										
Task 2. Identify the most relevant MCOs to form agreements with by considering the answers to the following questions: Is the MCO actuarially sound? Does it have a good reputation among patients and other providers? Is the plan coverage booklet clear and comprehensive? Do enrollees switch frequently from one primary care physician to another? What is the role of the primary care physician? Does it pay providers on time in accordance with its contractual obligations?										
Task 3. Determine and finalize the conditions of the agreement including service coordination										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	0	0	0	50	100	200	217	217	217
Task 1. PPS will inventory the number of primary care practices that have attested to this project and compare it to the list of adult primary care practices that are part of the PPS' network										
Task 2. PPS will identify the primary care practices that have not engaged in this project and develop a multi-pronged action plan to promote engagement and participation of practices in this project										
Task 3. PPS Staff and consultants as appropriate will engage practices in a series of training and technical assistance										

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activities to ensure that primary care practices are provided the support they need to adopt the broad range of practices, protocols, and processes that are part of the Millions Heart Initiative. (The body of evidence and experience suggests that simply distributing the protocols and policies to practices will not lead to broad, far reaching change.)										
Task 4. PPS will assess participation rates on a regular basis and continue to implement its action plan until the PPS achieves the 80% threshold										

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. Convene Project Implementation Collaborative (PIC)										
Task 2. Conduct a systematic review and environmental scan of participating partners/providers' practices regarding CVD										
Task 3. Conduct a review of community CVD needs, resources, and service/system gaps										
Task 4. Review literature and identify evidence based strategies for best practices										
Task 5. Compare current organizational practices with best practice and adopt evidence-based protocols										
Task 6. Educate health care providers and administrators about the importance/benefit of systematic approaches and/or organizational changes needed to enhance population health										
Task 7. Identify strategic priorities endorsed by providers and administrators										

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Task 8. Develop a strategic improvement and monitoring plan and implement										
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.	38	46	46	46	46	46	46	46	46	46
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	125	149	149	149	149	149	149	149	149	149
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	20	23	23	23	23	23	23	23	23	23
Task PPS uses alerts and secure messaging functionality.										
Task 1. Develop functional specifications for data exchange to support project requirements and use cases including supported payloads and modes of exchange										
Task 2. Complete CNYCC partner HIT readiness assessment using surveys and provider specific follow-up, including HIE/RHIO participation and Direct Exchange capabilities										
Task 3. Prioritize partners/vendor engagements with top priority to those currently capable and willing to participate in standards compliant exchange										
Task 4. Develop partner connectivity strategy based on the findings from the current state assessment accounting for partners/vendors currently incapable of participating in standards compliant exchange										
Task 5. Develop plan to standardize on Direct Messaging and the C-CDA, including the rollout of Direct enabled web-based platforms										
Task 6. Convene with project participants/providers to define alerting use cases to help support project activities.										

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Task 7. Work with applicable project partners and their respective vendors to implement connectivity strategy										
Task 8. Roll out QE access to participating partner organizations, including patient lookup services and identified alerting use cases										
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.	97	217	217	217	217	217	217	217	217	217
Task 1. Identify all participating safety net primary care practices and associated providers										
Task 2. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 3.a) Define Meaningful Use Stage 2 requirements and align/incorporate cardiovascular disease management strategies with those requirements.										
Task 3b) Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate cardiovascular disease management strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 4. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding MU Stage 2 and NCQA PCMH 2014. Education will include review of MU Stage 2 measures, NCQA 2014 standards, scoring, and recognition process.										
Task 5. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 6. Conduct baseline assessments of providers/practices' MU										

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Stage 2 and PCMH 2014 statuses.										
Task 7. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful MU Stage 2 attestation and PCMH 2014 implementations.										
Task 8. Devise a detailed MU Stage 2 and PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										
Task 9. Deploy MU Stage 2 and PCMH 2014 or APCM implementation plans for each participating provider/practice.										
Task 10. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 11. Participating providers successfully complete MU Stage 2 attestation.										
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. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements as well as care cardiovascular disease management and identify the expected sources of data.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										

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Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform.										
Task 7. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 8. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
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. Work with Public Health staff and partner organizations to conduct trainings (i.e. in person, train the trainer, etc.) on 1) the 5A model, including the value in linking patients to community organizations, 2) motivational interviewing, 3) cultural competency, and 4) tobacco treatment resources										
Task 2. Create an inventory of linguistically appropriate tobacco treatment resources (local, regional and statewide) and work towards a bi-lateral referral process among health care and community-based organizations										
Task 3. Work with project partners and their respective EHR vendors to assess their capability to support workflow automation										
Task 4. Develop 5A's script and workflow for brief intervention to be offered by providers if patient tobacco use is identified										
Task 5. Train providers (via written materials, in-person meetings, or training the trainer approaches) how to input consistent information (for example tobacco use diagnosis, billing codes and patient referral response) into the EHR										
Task 6. In collaboration with Public Health Department, develop and										

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disseminate brochures, PowerPoint slides, and job aids to implement the 5A's (including a chart that explains insurance coverage, pharmacotherapy and dosing guide, and which reinforces combination therapy)										
Task 7. Provide ongoing technical assistance on tobacco treatment, motivational interviewing, cultural competency, and resources to clinic staff										
Task 8. Work with partners and their respective EMR vendors to implement automated workflow for identified interventions and required prompts										
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. Identify and institutionalize a standardized hypertension protocol through the 3bi PIC. The PIC will draw from its literature review of best/prove practices to develop the standardized protocol and then will conduct trainings ((i.e. in person, train the trainer, etc.) to standardized protocol in a participating practices										
Task 2. Designate hypertension champions within organization										
Task 3. Create an inventory of linguistically appropriate hypertension and cholesterol treatment resources (local, regional and statewide) and work towards a referral process among health care and community based organizations										
Task 4. Work with Public Health staff and other partner organizations to provide trainings (i.e. in person, train the trainer, etc.) on 1) current screening and treatment protocols for hypertension and elevated cholesterol, 2) motivational interviewing, 3) cultural competency, 4) treatment value in linking patients to community organizations/resources										
Task 5. Develop motivational interviewing script and work flow for brief intervention to be offered by providers if risk factors are identified										

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Task 6. Train providers (via written materials, in-person meetings, or training the trainer approaches) on how to input consistent information on risk factors and test results into the EHR										
Task 7. In collaboration with Public Health Department and other health and community organizations, develop and disseminate brochures, PowerPoint slides, and job aids to implement the hypertension and high cholesterol prevention and treatment protocols (including a chart that explains insurance coverage, medication and dosing guide)										
Task 8. Provide ongoing technical assistance on hypertension and high cholesterol treatment, motivational interviewing, cultural competency, and resources to clinical and other staff as appropriate										
Task 9. Work with partners and their respective EMR vendors to implement automated workflow for identified interventions and required prompts										
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. Identify financing and care coordination tools (e g , Care Coordination Measures Atlas, developed by the Agency for Healthcare Research and Quality) and codes which allow physicians to document and bill for coordinating care between community service agencies, linking patients to resources, supporting the transition of patients from inpatient to other settings, and working to limit preventable readmissions										
Task 2. Develop and institutionalize a care coordination team model										

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that outlines multidisciplinary member roles and responsibilities and is centered on the comprehensive needs of the patient and family, leading to decreased health care costs, reduction in fragmented care, and improvement in the patient/family experience of care										
Task 3. Using identified tools, increase awareness among multi-disciplinary health care and community workers about the benefits of care coordination										
Task 4. Work with project partners and their respective EHR vendors to assess their capability to document patients' lifestyle behaviors and medication adherence according to the care coordination model and which considers health literacy issues, patient self-efficacy										
Task 5. Develop and institutionalize a mobile care coordination team to travel to high-risk/need areas (or a system for transporting high-risk patients to the care coordination team)										
Task 6. Train care coordination team (i.e. in person, train the trainer, etc.) in the development of a culturally appropriate coordinated care plan to be used across the continuum of care by medical, educational, mental health, community, and home care provider										
Task 7. Develop monitoring plan for ensuring effective coordinated care and patient plans										
Task 8. Work with partners and their respective EMR vendors to implement care coordination documentation requirements										
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.	200	217	217	217	217	217	217	217	217	217
Task 1. Identify and promote existing health care facilities and community-based organizations/events which have properly maintained blood pressure monitors and walk-in clinics										
Task 2. Develop and institutionalize a mobile health van to travel to high-risk/high-need areas (places where high-risk people may congregate such as WIC clinics, refugee resettlement agencies, social service settings, etc.)										

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Task 3. Develop and disseminate materials/digital communications that guide patients in the use of home-based blood pressure devices and availability of drop-in blood pressure readings										
Task 4. Train (i.e. in person, train the trainer, etc.) clerical personnel in proper blood pressure measurement technique so they are capable of obtaining drop-in blood pressure readings										
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.										
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.										
Task 1. Develop an evidence-based protocol for training staff on blood pressure measurement and equipment maintenance										
Task 2. Conduct annual mandatory trainings to all new and existing staff involved in measuring and recording blood pressure to ensure competency										
Task 3. Designate champions within the organizations										
Task 4. Develop a tracking system for monitoring training and proficiency										
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. Convene with project participants/providers to inventory criteria that would be required for the identification, risk stratification, and engagement of patients for the project										

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Task 2. Finalize risk stratification requirements, including inclusion/exclusion criteria, metric definitions, clinical value thresholds and risk scoring algorithm.										
Task 3. Develop motivational interviewing script and work flow for brief intervention to be offered by providers if repeated elevated blood pressure readings are identified and patient is scheduled for hypertension visit										
Task 4. Identify core data elements needed for risk stratification requirements.										
Task 5. Work with project partners and their respective EHR vendors to assess their capability to support workflow automation to facilitate scheduling of target patient population										
Task 6. Complete gap analysis to compare required data to currently available data.										
Task 7. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 8. Work with participating partners and their EMR vendors to identify local risk stratification capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
Task 9. Complete inventory of HIT-related PHM deliverables and current use cases to support project requirements										
Task 10. Finalize required functionality and select a PHM software vendor										
Task 11. Finalize population health management roadmap to support identified data/analytics requirements, and care coordination strategies (including method for collaborative care planning) and obtain board approval.										
Task 12. Work with partners and their respective EMR vendors to implement automated workflow for appointment scheduling										
Task 13. Implement PHM roadmap										

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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. Identify and institutionalize a standardized hypertension protocol										
Task 2. Designate hypertension champions within organization										
Task 3. Prescribe once-daily regimens or fixed-dose combination pills when appropriate										
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. Provide trainings (i.e. in person, train the trainer, etc.) on 1) the value of patient driven self-management goals in the medical record 2) motivational interviewing, and 3) cultural competency										
Task 2. Work with project partners and their respective EHR vendors to assess their capability to document patients' self-management goals										
Task 3. Develop scripts and workflow for review of self-management goals to be used by providers at each visit										
Task 4. Train providers how to input consistent self-management goals into the medical record										
Task 5. Provide ongoing technical assistance on patient driven self-management goals in the medical record to clinic staff										
Task 9. Work with partners and their respective EMR vendors to implement care coordination documentation requirements										

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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. Provide trainings (i.e. in person, train the trainer, etc.) on 1) the value of patient driven self-management goals in the medical record 2) motivational interviewing, and 3) cultural competency										
Task 2. Contact community based organizations and engage administration in planning for referral systems Develop MOU's regarding referral workflows and how to address referral issues/problems Establish Business Associate Agreements (BAA), which adhere to HIPAA requirements										
Task 3. To the degree possible establish mechanisms for community based organizations to report back client status changes in a manner that upholds HIPAA requirements										
Task 4. Create and systematize a referral mechanism to each health and community based organization involved, which meets their referral criteria and format Include verbal referral or warmline transfer, paper fax or direct EMR referrals										
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.										

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Task PPS provides periodic training to staff on warm referral and follow-up process.										
Task 1. Create an inventory of protocols and identify most appropriate ones for target population										
Task 2. Provide trainings on the value of home blood pressure monitoring										
Task 3. Provide blood pressure monitoring training to patients										
Task 4. Assign appropriate person to conduct follow ups										
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 criteria for selecting patients with hypertension in need of follow-up visits										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking follow-up.										
Task 3. Work with project partners and their respective EHR vendors to assess their capability to support workflow automation to facilitate scheduling of target patient population identified in reports.										
Task 4. Run an analysis of prior visit dates against list of patients with hypertension and identify those in need of a follow up appointment										
Task 5. Work with partners and their respective EMR vendors to implement care coordination documentation requirements										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task 1. Train ((i.e. in person, train the trainer, etc.) providers in										

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understanding the efficacy of and services provided by the NYS Smoker's Quitline Services Reinforce the 5A's so that providers a) identify tobacco users at every patient encounter, b) intervene with each tobacco user and c) refer to the Quitline										
Task 2. Utilize the comprehensive training and guidance materials that are available on the NYS Smokers' Quitline website										
Task 3. Implement 5A's script and workflow for brief intervention to be offered by providers if patient tobacco use is identified										
Task 4. Implement an EMR system that has the capacity to make on the spot NYS Smokers' Quitline referrals through their secure on-line referral or fax referral system										
Task 5. Create a mechanism for NYS Smokers' Quitline progress report to be added to the patient record once received										
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. Convene with project participants/providers to inventory criteria that would be required for the identification, risk stratification, and engagement of patients for the project										
Task 2. Finalize risk stratification requirements, including inclusion/exclusion criteria, metric definitions, clinical value thresholds and risk scoring algorithm.										
Task 3. Identify and train individuals with at least one chronic condition to facilitate chronic disease self-management workshops in community settings such as senior centers,										

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churches, libraries, clinics, and hospitals										
Task 4. Schedule workshops in high-risk neighborhoods										
Task 5. Provide trainings on Stanford Model for chronic diseases including the value in linking patients to community organizations/resources to healthcare providers										
Task 6. Identify core data elements needed for risk stratification requirements.										
Task 7. Complete gap analysis to compare required data to currently available data.										
Task 8. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 9. Work with participating partners and their EMR vendors to identify local risk stratification capabilities, as well as mechanisms to extract and share required data elements for PPS wide data aggregation in CNYCC Population Health Management Platform.										
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.	217	217	217	217	217	217	217	217	217	217
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	538	538	538	538	538	538	538	538	538	538
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	36	36	36	36	36	36	36	36	36	36
Task 1. Identify local and regional contacts and linkages who have participated in the Million Hearts Campaign planning, implementation and evaluation activities										
Task 2. Develop an inclusive and multi-disciplinary leadership group made up of health care institutions, community based										

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organizations and individual stakeholders										
Task 3. Join the Guiding Coalition by signing up on-line to access resources and get involved										
Task 4. Review Million Hearts Campaign report and identify asset based core strategies implemented through workgroups										
Task 5. Register for and participate in scheduled member connection calls/webinars										
Task 6. Establish hypertension and high level cholesterol work groups to develop an implementation plan for each of the six core strategies, which focus on improving health care systems through community collaboration and partnership and sustainable business models co-designed with people who the health care systems are designed to serve										
Task 7. Strategy: Identify and use data to ascertain problem areas										
Task 8. Strategy: Identify interventions with the highest probability of decreasing harm, mortality, or readmission rates Ensure strategies are appropriate for intended short, intermediate and long term outcomes										
Task 9. Strategy: Start in areas that are likely to show early success										
Task 10. Develop monitoring plan for ensuring implementation of strategies										
Task 11. Evaluate progress at regular intervals and identify areas needing revision/adjustment										
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. Investigate MCOs serving affected populations to assess its										

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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
market share, service area, stability, solvency, and reputation										
Task 2. Identify the most relevant MCOs to form agreements with by considering the answers to the following questions: Is the MCO actuarially sound? Does it have a good reputation among patients and other providers? Is the plan coverage booklet clear and comprehensive? Do enrollees switch frequently from one primary care physician to another? What is the role of the primary care physician? Does it pay providers on time in accordance with its contractual obligations?										
Task 3. Determine and finalize the conditions of the agreement including service coordination										
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.	217	217	217	217	217	217	217	217	217	217
Task 1. PPS will inventory the number of primary care practices that have attested to this project and compare it to the list of adult primary care practices that are part of the PPS' network										
Task 2. PPS will identify the primary care practices that have not engaged in this project and develop a multi-pronged action plan to promote engagement and participation of practices in this project										
Task 3. PPS Staff and consultants as appropriate will engage practices in a series of training and technical assistance activities to ensure that primary care practices are provided the support they need to adopt the broad range of practices, protocols, and processes that are part of the Millions Heart Initiative. (The body of evidence and experience suggests that simply distributing the protocols and policies to practices will not lead to broad, far reaching change.)										
Task 4. PPS will assess participation rates on a regular basis and continue to implement its action plan until the PPS achieves the 80% threshold										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	
Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Use EHRs or other technical platforms to track all patients engaged in this project.	
Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	
Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	
Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	
Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
Document patient driven self-management goals in the medical record and review with patients at each visit.	
Follow up with referrals to community based programs to document participation and behavioral and health status changes.	
Develop and implement protocols for home blood pressure monitoring with follow up support.	
Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	
Facilitate referrals to NYS Smoker's Quitline.	
Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	
Adopt strategies from the Million Hearts Campaign.	
Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	
Engage a majority (at least 80%) of primary care providers in this project.	

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IPQR Module 3.b.i.5 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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 Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 3.b.i.6 - IA Monitoring

Instructions :

Milestone 20: PPS should develop and submit task that demonstrate how this project requirement will be accomplished; Recommend the PPS delineate the major steps planned to engage at least 80% of their PCPs.

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Central New York Care Collaborative, Inc. (PPS ID:8)

Project 3.g.i – Integration of palliative care into the PCMH Model

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

Instructions :

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

1. Risk: Societal views on death and dying may stymie the full potential of this project. Furthermore, health professionals are not always adequately trained and prepared to deliver "basic" or "primary" palliative care to patients, including lack of communication skills among providers to have honest, sensitive, and culturally competent conversations with patients and their caregivers on health status, goals, and advance directives. Potential Impact: Processes and systems may be put in place within PCMHs to provide basic palliative care services to patients in the primary care setting that ultimately are not meaningful to the patient and therefore not fully or even adequately addressing pain and symptom management of their disease or discussion of their health and treatment goals. As a result, palliative care patients may not have full understanding of their disease process, inability to self-manage and utilize services or resources within the community or health system to support management, and continue accessing urgent care through the ED, which could otherwise be prevented. Furthermore, patients may receive unwanted treatment if they haven't fully considered and/or documented their treatment options and preferences. Mitigation: Mitigation of this risk will depend on ensuring available and supported training opportunities for health care professionals participating in 3gi on palliative care and patient communication skills to develop competency and capacity in conversations on health status, care goals, and advance directives. The Conversation Ready Project (Institutes for Healthcare Improvement), Compassion and Support, and Centers to Advance Palliative Care are resources for these training needs. Second, providing public education and engagement about death, dying, and end-of-life care issues at the individual/patient, family/caregiver and community levels will help normalize conversations about death and dying and facilitate thoughtful and meaningful discussions with health care providers in establishing care goals, plans, and advance directives.

2. Risk: Palliative care is not a clear priority among primary care providers. Potential Impact: If this project and/or palliative care are not adopted as a priority component of providing comprehensive, quality, patient-centered care, there may be slow uptake and implementation of this project that will result in the PPS not achieving project milestones on time nor engaging patients per the planned timeline. Mitigation of this risk will require leadership at the PPS, regional, and practice levels, physician champions in each 3gi project practice, to provide vision and direction to comprehensively integrate palliative care into the outpatient/primary care setting.

3. Risk: A systematic way to identify and monitor palliative care patients is lacking. Potential Impact: If eligible palliative care patients are not identified within a practice and monitored for provision of appropriate services and supports to manage pain and symptoms associated with their disease, they will likely experience poor control and/or worsening of their symptoms that may result in otherwise preventable use of the ED and hospital. Mitigation: Introduction of a population health management platform within the PPS will enable the systematic identification and tracking of high risk populations and the ability to track their care throughout the continuum. In the interim, the outpatient palliative care population will be tracked through registries or reports built directly in the participating practice/organization EMRs.

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Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 3.g.i.2 - Project Implementation Speed

Instructions :

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

Benchmarks
100% Total Committed By
DY3,Q4

Provider Type	Total Commitment	Year,Quarter (DY1,Q1 – DY3,Q2)									
		DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Primary Care Physicians	181	0	0	0	0	0	0	0	0	0	0
Non-PCP Practitioners	576	0	0	0	0	0	0	0	0	0	0
Clinics	20	0	0	0	0	0	0	0	0	0	0
Hospice	4	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	4	0	0	0	0	0	0	0	0	0	0
All Other	410	0	0	0	0	0	0	0	0	0	0
Total Committed Providers	**1,195**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Percent Committed Providers(%)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Provider Type	Total Commitment	Year,Quarter (DY3,Q3 – DY5,Q4)									
		DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Primary Care Physicians	181	0	181	181	181	181	181	181	181	181	181
Non-PCP Practitioners	576	0	576	576	576	576	576	576	576	576	576
Clinics	20	0	20	20	20	20	20	20	20	20	20
Hospice	4	0	4	4	4	4	4	4	4	4	4
Community Based Organizations	4	0	4	4	4	4	4	4	4	4	4
All Other	410	0	410	410	410	410	410	410	410	410	410
Total Committed Providers	**1,195**	**0**	**1,195**	**1,195**	**1,195**	**1,195**	**1,195**	**1,195**	**1,195**	**1,195**	**1,195**
Percent Committed Providers(%)		**0.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**	**100.00**

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Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Project requirement 5, "Engage with Medicaid Managed Care to address coverage of services" will likely not be met until outcomes data is being generated by the project that will enable negotiations with MCOs. Since that requirement is assigned to the project unit level, no individual providers can meet all of the project requirements (as set out in the project Plan Application) until that date. We believe this project requirement represents the "rate limiting" requirement for Project 3gi because the nature of the interaction with Managed Care to this end will be to describe the penetration of the project into the system (extent to which other requirements have already been completed among partners) and the cost benefit analysis, requiring adequate and representative outcome data to be collected which will occur late in the DSRIP period. For example, DY3Q4's claims window for which outcome measures will be computed (Measurement Year 2) is July 1, 2016 to June 30, 2017, which is the earliest MY during which project implementation will occur. It seems unlikely that adequate outcome data will be available until at least DY3Q4, which is also the deadline for all project requirements being met by all participating providers.

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IPQR Module 3.g.i.3 - Patient Engagement Speed

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	8,800

Year,Quarter (DY1,Q1 – DY3,Q2)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Patients Engaged	0	0	0	0	0	0	0	1,100	1,650	2,200
Percent of Expected Patient Engagement(%)	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**12.50**	**18.75**	**25.00**

Year,Quarter (DY3,Q3 – DY5,Q4)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Patients Engaged	2,200	4,400	2,200	4,400	6,600	8,800	2,200	4,400	6,600	8,800
Percent of Expected Patient Engagement(%)	**25.00**	**50.00**	**25.00**	**50.00**	**75.00**	**100.00**	**25.00**	**50.00**	**75.00**	**100.00**

Current File Uploads

User ID	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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IPQR Module 3.g.i.4 - Prescribed Milestones

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Project	N/A	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	Provider	Primary Care Physicians	In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. PCMH Level 1 Recognition	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 1a Identify all providers/practices participating in project and identify those with or who will achieve NCQA PCMH 2014 Level 1 recognition.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 1b. Establish HIT/HIE and Primary Care Transformation workgroups.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 1c. Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate palliative care strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.	Project		In Progress	09/01/2015	01/31/2016	03/31/2016	DY1 Q4
Task 1d. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding NCQA PCMH 2014. Education will include review of, NCQA 2014 standards, scoring, and recognition process.	Project		In Progress	08/04/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1e. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.	Project		In Progress	08/04/2015	11/01/2015	12/31/2015	DY1 Q3
Task 1f. Conduct baseline assessments of providers/practices' PCMH 2014 statuses.	Project		In Progress	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	01/01/2016	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
1g. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful PCMH 2014 implementations.							
Task 1h. Devise a detailed PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.	Project		In Progress	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1i. Deploy PCMH 2014 or APCM implementation plans for each participating provider/practice.	Project		In Progress	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1j. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.	Project		In Progress	09/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 2. Establish regional Palliative Care Resource Teams composed of palliative care physician, mid-level and nurse case manager.	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2
Task 3. Implement palliative care change package (i.e., palliative care patient panel, palliative care patient assessment protocol, and palliative care patient care plan protocol) in PCMHs. See also Requirement #3	Project		In Progress	10/01/2015	10/31/2016	12/31/2016	DY2 Q3
Task 3a Introduce palliative care change package to PCMH cohorts	Project		In Progress	10/01/2015	10/31/2016	12/31/2016	DY2 Q3
Task 3b Provide Technical Assistance to PCMH cohorts to guide implementation of palliative care change package	Project		In Progress	10/01/2015	10/31/2016	12/31/2016	DY2 Q3
Task 3d. Participating practices conduct workflow analysis to assess capacity for integrating palliative care into practice	Project		In Progress	10/01/2015	10/31/2016	12/31/2016	DY2 Q3
Task 3e. Participating PCPs establish palliative care patient panel of patients at highest risk for ED/Inpatient use(patient finding and targeting)	Project		In Progress	10/01/2015	10/31/2016	12/31/2016	DY2 Q3
Task 3f. Participating PCPs implement palliative care patient assessment and care plan protocols	Project		In Progress	10/01/2015	10/31/2016	12/31/2016	DY2 Q3
Task 4. Providers/practices engage community partners and resources and establish referral mechanisms	Project		In Progress	10/01/2015	10/31/2016	12/31/2016	DY2 Q3
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Project	N/A	In Progress	08/04/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.	Project		In Progress	08/04/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Review and document community partners, resources and social support services available regionally and within communities for PCMHs to coordinate with regarding palliative care services (e.g., hospitals, hospices, home care, nursing homes, social services, economic services, public health programs)	Project		In Progress	08/04/2015	08/31/2016	09/30/2016	DY2 Q2
Task 2. Identify which services and resources to link to or integrate into practices providing palliative care services	Project		In Progress	08/04/2015	08/31/2016	09/30/2016	DY2 Q2
Task 3. Identify and engage core partner agencies and related services/resources	Project		In Progress	08/04/2015	08/31/2016	09/30/2016	DY2 Q2
Task 4. Develop guide for referral protocols and procedures with partners agencies and other provider/community resources	Project		In Progress	08/04/2015	08/31/2016	09/30/2016	DY2 Q2
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Project	N/A	In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.	Project		In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Convene Project Implementation Collaborative meetings to steer the initiative	Project		In Progress	06/15/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Define scope of palliative care services and change package to be integrated in PCMHs (e.g., pain and symptom assessment and management, advance care planning, panel management)	Project		In Progress	06/15/2015	08/31/2015	09/30/2015	DY1 Q2
Task 3a. Conduct review of existing palliative care clinical guidelines	Project		In Progress	06/15/2015	08/31/2015	09/30/2015	DY1 Q2
Task 3b. Define palliative care guidelines to be integrated in PCMHs	Project		In Progress	06/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3c. Define general patient eligibility criteria for receipt of palliative care services	Project		In Progress	06/15/2015	08/31/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
in PCMH							
Task 3d. Define general criteria for patient referral to specialty, hospital, home care, nursing home, and/or hospice services	Project		In Progress	06/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3e. Review palliative care services and change package with PPS partners; establish consensus on defined palliative care clinical guidelines, eligibility, and referral	Project		In Progress	06/15/2015	10/31/2015	12/31/2015	DY1 Q3
Task 3. Develop or identify a patient health severity assessment tool for PCMHs	Project		In Progress	06/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Develop a patient palliative care plan template for PCMHs	Project		In Progress	06/15/2015	10/31/2015	12/31/2015	DY1 Q3
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Project	N/A	In Progress	10/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.	Project		In Progress	10/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify core competencies for providing palliative care in PCMH setting	Project		In Progress	10/31/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Develop or identify online and in-person training for palliative care competency, including cultural competency	Project		In Progress	12/01/2015	02/28/2016	03/31/2016	DY1 Q4
Task 3. Implement trainings	Project		In Progress	10/31/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Project	N/A	In Progress	10/31/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.	Project		In Progress	10/31/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS conducts analysis of the scope of services identified for the defined population	Project		In Progress	10/31/2016	12/31/2016	12/31/2016	DY2 Q3
Task servicesPPS develops preliminary value based payment option for project based on previous step (Total Care, Bundled Care etc)	Project		In Progress	12/01/2016	01/31/2017	03/31/2017	DY2 Q4
Task 3. PPS conducts cost benefit analysis of projects and adjusts value based payment option (including services and population definition).	Project		In Progress	04/01/2017	09/30/2017	09/30/2017	DY3 Q2
Task	Project		In Progress	04/01/2017	09/30/2017	09/30/2017	DY3 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
4. PPS develops measures and metrics for the value-based payment strategy							
Task . PPS collaborates with MCOs to assure proposed approaches are synergistic with MCO efforts.	Project		In Progress	04/01/2017	09/30/2017	09/30/2017	DY3 Q2
Task 6. PPS engages partners to review and refine preliminary value-based approaches, with particular focus on assuring their participation.	Project		In Progress	10/01/2017	12/31/2017	12/31/2017	DY3 Q3
Task 7. PPS engages MCOs in contractual discussions regarding project, finalizes scope, population, approach, measures; resulting in contractual agreement with PPS.	Project		In Progress	01/01/2018	03/31/2018	03/31/2018	DY3 Q4
Task 8. PPS engages partners in contractual discussions regarding project; resulting in contractual agreement with PPS.	Project		In Progress	01/01/2018	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Project	N/A	In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.	Project		In Progress	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.	Project		In Progress	10/01/2015	04/30/2016	06/30/2016	DY2 Q1
Task 3. Identify core data elements needed for patient tracking requirements as well as care coordination data and identify the expected sources of data.	Project		In Progress	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Complete gap analysis to compare required data to currently available data.	Project		In Progress	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.	Project		In Progress	04/01/2016	07/31/2016	09/30/2016	DY2 Q2
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform	Project		In Progress	09/01/2015	08/31/2016	09/30/2016	DY2 Q2

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.										
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	0	0	0	0	0	0	0	25	50	100
Task 1. PCMH Level 1 Recognition										
Task 1a Identify all providers/practices participating in project and identify those with or who will achieve NCQA PCMH 2014 Level 1 recognition.										
Task 1b. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 1c. Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate palliative care strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 1d. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding NCQA PCMH 2014. Education will include review of, NCQA 2014 standards, scoring, and recognition process.										
Task 1e. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 1f. Conduct baseline assessments of providers/practices' PCMH 2014 statuses.										
Task 1g. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful PCMH 2014 implementations.										
Task 1h. Devise a detailed PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
concurrently.										
Task 1i. Deploy PCMH 2014 or APCM implementation plans for each participating provider/practice.										
Task 1j. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 2. Establish regional Palliative Care Resource Teams composed of palliative care physician, mid-level and nurse case manager.										
Task 3. Implement palliative care change package (i.e., palliative care patient panel, palliative care patient assessment protocol, and palliative care patient care plan protocol) in PCMHs. See also Requirement #3										
Task 3a Introduce palliative care change package to PCMH cohorts										
Task 3b Provide Technical Assistance to PCMH cohorts to guide implementation of palliative care change package										
Task 3d. Participating practices conduct workflow analysis to assess capacity for integrating palliative care into practice										
Task 3e. Participating PCPs establish palliative care patient panel of patients at highest risk for ED/Inpatient use(patient finding and targeting)										
Task 3f. Participating PCPs implement palliative care patient assessment and care plan protocols										
Task 4. Providers/practices engage community partners and resources and establish referral mechanisms										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										
Task 1. Review and document community partners, resources and										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
social support services available regionally and within communities for PCMHs to coordinate with regarding palliative care services (e.g., hospitals, hospices, home care, nursing homes, social services, economic services, public health programs)										
Task 2. Identify which services and resources to link to or integrate into practices providing palliative care services										
Task 3. Identify and engage core partner agencies and related services/resources										
Task 4. Develop guide for referral protocols and procedures with partners agencies and other provider/community resources										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.										
Task 1. Convene Project Implementation Collaborative meetings to steer the initiative										
Task 2. Define scope of palliative care services and change package to be integrated in PCMHs (e.g., pain and symptom assessment and management, advance care planning, panel management)										
Task 3a. Conduct review of existing palliative care clinical guidelines										
Task 3b. Define palliative care guidelines to be integrated in PCMHs										
Task 3c. Define general patient eligibility criteria for receipt of palliative care services in PCMH										
Task 3d. Define general criteria for patient referral to specialty, hospital, home care, nursing home, and/or hospice services										
Task 3e. Review palliative care services and change package with PPS partners; establish consensus on defined palliative care										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
clinical guidelines, eligibility, and referral										
Task 3. Develop or identify a patient health severity assessment tool for PCMHs										
Task 4. Develop a patient palliative care plan template for PCMHs										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task 1. Identify core competencies for providing palliative care in PCMH setting										
Task 2. Develop or identify online and in-person training for palliative care competency, including cultural competency										
Task 3. Implement trainings										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task PPS conducts analysis of the scope of services identified for the defined population										
Task servicesPPS develops preliminary value based payment option for project based on previous step (Total Care, Bundled Care etc)										
Task 3. PPS conducts cost benefit analysis of projects and adjusts value based payment option (including services and population definition).										
Task 4. PPS develops measures and metrics for the value-based payment strategy										
Task . PPS collaborates with MCOs to assure proposed approaches are synergistic with MCO efforts.										

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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. PPS engages partners to review and refine preliminary value-based approaches, with particular focus on assuring their participation.										
Task 7. PPS engages MCOs in contractual discussions regarding project, finalizes scope, population, approach, measures; resulting in contractual agreement with PPS.										
Task 8. PPS engages partners in contractual discussions regarding project; resulting in contractual agreement with PPS.										
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements as well as care coordination data and identify the expected sources of data.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform										

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										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.										
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	150	181	181	181	181	181	181	181	181	181
Task 1. PCMH Level 1 Recognition										
Task 1a Identify all providers/practices participating in project and identify those with or who will achieve NCQA PCMH 2014 Level 1 recognition.										
Task 1b. Establish HIT/HIE and Primary Care Transformation workgroups.										
Task 1c. Engage and collaborate with PCMH Certified Content Expert to review NCQA PCMH 2014 Level 3 requirements and integrate palliative care strategies into a PCMH baseline assessment tool and implementation strategy for primary care providers.										
Task 1d. Provide HIT/HIE and Primary Care Transformation Workgroups education regarding NCQA PCMH 2014. Education will include review of, NCQA 2014 standards, scoring, and recognition process.										
Task 1e. Identify practice transformation champions to drive HIT/HIE and PCMH implementation for each primary care practice.										
Task 1f. Conduct baseline assessments of providers/practices' PCMH 2014 statuses.										
Task 1g. Devise cohort groups and facilitate learning collaborative sessions to support practices in successful PCMH 2014 implementations.										
Task 1h. Devise a detailed PCMH 2014 implementation plan for each provider/practice. As MU Stage 2 measures are embedded in PCMH 2014 standards both will be assessed and implemented concurrently.										

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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 1i. Deploy PCMH 2014 or APCM implementation plans for each participating provider/practice.										
Task 1j. PCMH 2014 Level 3 recognition achieved or APCM by participating primary care practices.										
Task 2. Establish regional Palliative Care Resource Teams composed of palliative care physician, mid-level and nurse case manager.										
Task 3. Implement palliative care change package (i.e., palliative care patient panel, palliative care patient assessment protocol, and palliative care patient care plan protocol) in PCMHs. See also Requirement #3										
Task 3a Introduce palliative care change package to PCMH cohorts										
Task 3b Provide Technical Assistance to PCMH cohorts to guide implementation of palliative care change package										
Task 3d. Participating practices conduct workflow analysis to assess capacity for integrating palliative care into practice										
Task 3e. Participating PCPs establish palliative care patient panel of patients at highest risk for ED/Inpatient use(patient finding and targeting)										
Task 3f. Participating PCPs implement palliative care patient assessment and care plan protocols										
Task 4. Providers/practices engage community partners and resources and establish referral mechanisms										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										
Task 1. Review and document community partners, resources and social support services available regionally and within communities for PCMHs to coordinate with regarding palliative										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
care services (e.g., hospitals, hospices, home care, nursing homes, social services, economic services, public health programs)										
Task 2. Identify which services and resources to link to or integrate into practices providing palliative care services										
Task 3. Identify and engage core partner agencies and related services/resources										
Task 4. Develop guide for referral protocols and procedures with partners agencies and other provider/community resources										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.										
Task 1. Convene Project Implementation Collaborative meetings to steer the initiative										
Task 2. Define scope of palliative care services and change package to be integrated in PCMHs (e.g., pain and symptom assessment and management, advance care planning, panel management)										
Task 3a. Conduct review of existing palliative care clinical guidelines										
Task 3b. Define palliative care guidelines to be integrated in PCMHs										
Task 3c. Define general patient eligibility criteria for receipt of palliative care services in PCMH										
Task 3d. Define general criteria for patient referral to specialty, hospital, home care, nursing home, and/or hospice services										
Task 3e. Review palliative care services and change package with PPS partners; establish consensus on defined palliative care clinical guidelines, eligibility, and referral										

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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. Develop or identify a patient health severity assessment tool for PCMHs										
Task 4. Develop a patient palliative care plan template for PCMHs										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task 1. Identify core competencies for providing palliative care in PCMH setting										
Task 2. Develop or identify online and in-person training for palliative care competency, including cultural competency										
Task 3. Implement trainings										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task PPS conducts analysis of the scope of services identified for the defined population										
Task servicesPPS develops preliminary value based payment option for project based on previous step (Total Care, Bundled Care etc)										
Task 3. PPS conducts cost benefit analysis of projects and adjusts value based payment option (including services and population definition).										
Task 4. PPS develops measures and metrics for the value-based payment strategy										
Task . PPS collaborates with MCOs to assure proposed approaches are synergistic with MCO efforts.										
Task 6. PPS engages partners to review and refine preliminary										

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Central New York Care Collaborative, Inc. (PPS ID:8)

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
value-based approaches, with particular focus on assuring their participation.										
Task 7. PPS engages MCOs in contractual discussions regarding project, finalizes scope, population, approach, measures; resulting in contractual agreement with PPS.										
Task 8. PPS engages partners in contractual discussions regarding project; resulting in contractual agreement with PPS.										
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Finalize definition for actively engaged patients to be used by participating CNYCC partners.										
Task 2. Work with participating partners and their EMR vendors to identify reporting mechanisms and criteria for tracking project participation.										
Task 3. Identify core data elements needed for patient tracking requirements as well as care coordination data and identify the expected sources of data.										
Task 4. Complete gap analysis to compare required data to currently available data.										
Task 5. Identify plans to address gaps and institute data governance rules to ensure that required data is captured consistently and timely.										
Task 6. Work with participating partners and their EMR vendors to identify mechanisms to extract and share required data elements for PPS wide data aggregation/tracking in CNYCC Population Health Management Platform										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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Central New York Care Collaborative, Inc. (PPS ID:8)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	
Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	
Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	
Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	
Engage with Medicaid Managed Care to address coverage of services.	
Use EHRs or other IT platforms to track all patients engaged in this project.	

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IPQR Module 3.g.i.5 - PPS Defined Milestones

Instructions :

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

Milestone/Task Name	Status	Description	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 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

Central New York Care Collaborative, Inc. (PPS ID:8)

IPQR Module 3.g.i.6 - IA Monitoring

Instructions :

Milestone 5: Recommend the PPS engage and develop agreements with appropriate MCOs around this palliative care project and provide details of steps to accomplish this.

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project 4.a.iii – Strengthen Mental Health and Substance Abuse Infrastructure across Systems

IPQR Module 4.a.iii.1 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones. For Domain 4 projects, these milestones must align with content submitted in the PPS Application.

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Convene Mental Emotional and Behavioral (MEB) Health Promotion and Disorder Prevention Regional Partnership, Designate a CNYCC Representative, and Assist the Partnership to Develop a Strategic Plan that is Aligned with DSRIP and Project 4aiii	In Progress	Convene Mental Emotional and Behavioral (MEB) Health Promotion and Disorder Prevention Regional Partnership, Designate a CNYCC Representative, and Assist the Partnership to Develop a Strategic Plan that is Aligned with DSRIP and Project 4aiii	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 1. Create an inventory of stakeholders, including organizations directly (e.g., public health) and in-directly (e.g., social services) related to MEB, and that also includes cohorts or specific populations targets members of the population served.	In Progress	Create an inventory of stakeholders, including organizations directly (e.g., public health) and in-directly (e.g., social services) related to MEB, as well members of the population served.	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Either identify an existing entity that would be willing to take on the work of the Partnership and align their efforts with the CNYCC's Project 4aiii goals/objectives or develop a new entity or organization willing to take on this work	In Progress	The Partnership could be developed through an RFP process. In this case, the guidance for the RFP would be developed by the PIC and the CNYCC. Requirements and expectations would be laid out in clear terms based on 4aiii project guidance and the will of the PIC and CNYCC staff	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Determine Prevention Partnership's organizational structure, by-laws, vision, mission, role, and core goals and activities	In Progress	Determine Prevention Partnership's organizational structure, by-laws, vision, mission, role, and core goals and activities	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Consolidate, review and summarize information from existing community needs assessment to clarify needs, underlying	In Progress	Consolidate, review and summarize information from existing community needs assessment to clarify needs, underlying determinants of health, population segments most at-risk, barrier to care/service, and service gaps.	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
determinants of health, population segments most at-risk, barrier to care/service, and service gaps.						
Task 5. Conduct a broad MEB policy or structural assessment and identify opportunities for promoting access to care, care coordination, service integration, client engagement, and outreach/education, particularly with respect to integrating and coordinating mental health and substance abuse services or breaking down the barriers to integration in these area,	In Progress	Conduct a broad MEB policy or structural assessment and identify opportunities for promoting access to care, care coordination, service integration, client engagement, and outreach/education, particularly with respect to integrating and coordinating mental health and substance abuse services or breaking down the barriers to integration in these area,	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Conduct resource mapping and develop an inventory of community and clinical providers, resources, and services available to support MEB health promotion, prevention, capacity building and overall MEB strengthening efforts	In Progress	Conduct resource mapping and develop an inventory of community and clinical providers, resources, and services available to support MEB health promotion, prevention, capacity building and overall MEB strengthening efforts	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Work with other CNYCC PICs and the CNYCC staff to explore and identify synergies and collaborative opportunities across the CNYCC's projects	In Progress	Work with other CNYCC PICs and the CNYCC staff to explore and identify synergies and collaborative opportunities across the CNYCC's projects	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 8. Engage the CNYCC's Workforce Coordination and the Workforce Working Group to explore overlapping objectives related to strengthening MEB Health workforce and building capacity, related to quality improvement, rapid cycle evaluation, and evidence-based approaches	In Progress	Engage the CNYCC's Workforce Coordination and the Workforce Working Group to explore overlapping objectives related to strengthening MEB Health workforce and building capacity, including capacity quality improvement, rapid cycle evaluation, and evidence-based approaches	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 9. Engage the CNYCC's Cultural Competency/ Health Literacy Working group to explore overlapping objectives related to ensuring that MEB health services are provided in a culturally competent way. Ensure that organizations are "health literate", as well as promoting health literacy related to MEB Health, particularly	In Progress	Engage the CNYCC's Cultural Competency/ Health Literacy Working group to explore overlapping objectives related to ensuring that MEB health services are provided in a culturally competent way. Ensure that organizations are "health literate", as well as promoting health literacy related to MEB Health, particularly amongst those most at-risk	09/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
amongst those most at-risk						
Task 10. Develop priorities for the partnership as well as a detailed work plan that will allow the partnership to achieve the identified priorities.	In Progress	Emphasis should be placed on identifying activities that will support the other work of the CNYCC and achievement of DSRIP goals. Priorities would likely fall into the following three categories 1) Capacity building efforts (e.g., psychiatry, telehealth, MH/SA/primary care integration, care management, medication management, etc.), 2) MEB Health Promotion, Wellness, and Prevention Activities (e.g., children/youth in schools, racial/ethnic minority populations, older adults, geographic service gaps, dual diagnosed individuals (MH & SA), etc., and 3) Advocacy and structural changes related to Broad MHSA Strengthening (policy consideration, licensure issues, training gaps, facility waivers and other regulatory waivers, etc.)	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 11. Designate a CNYCC representative by Year 1 Quarter 3 that would represent the CNYCC on the Partnership's leadership team	In Progress	Designate a CNYCC representative by Year 1 Quarter 3 that would represent the CNYCC on the Partnership's leadership team	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 12. Require that all CNYCC partners participate in Prevention Partnership	In Progress	Require that all CNYCC partners participate in Prevention Partnership	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Milestone Implement at Least Two Short-term and Two Long-term Objectives that are aligned with DSRIP Project 4aiii from the Prevention Partnership's Strategic Plan	In Progress	Implement at Least Two Short-term and Two Long-term Objectives that are aligned with DSRIP Project 4aiii from the Prevention Partnership's Strategic Plan	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 1. Identify existing resources that can be applied to achieve each of the identified short-term and long-term objectives.	In Progress	Identify existing resources that can be applied to achieve each of the identified short-term and long-term objectives.	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 2. Identify relevant "inputs" or activities required to achieve each of the short term and long-term objectives.	In Progress	Identify relevant "inputs" or activities required to achieve each of the short term and long-term objectives.	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 3. Develop logic model for each objective	In Progress	Develop logic model for each objective	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Develop detailed work plan with clear activities, timelines, measures/milestones for success and responsible parties for each objective	In Progress	Develop detailed work plan with clear activities, timelines, measures/milestones for success and responsible parties for each objective	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task	In Progress	Implement and monitor activities and use data for quality/progress improvement.	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
5. Implement and monitor activities and use data for quality/progress improvement						
Milestone Conduct Annual Reviews of Objectives and Activities to Determine Progress and Selection of New objectives and Activities.	In Progress	Conduct Annual Reviews of Objectives and Activities to Determine Progress and Selection of New objectives and Activities.	12/31/2015	03/31/2020	03/31/2020	DY5 Q4
Task 1. Train Prevention Partnership members on the principles and practices related to quality/performance improvement and rapid cycle evaluation	In Progress	Train Prevention Partnership members on the principles and practices related to quality/performance improvement and rapid cycle evaluation	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task 2. Based on the logic model and the work plan, develop an evaluation plan for each objective	In Progress	Based on the logic model and the work plan, develop an evaluation plan for each objective	01/01/2016	03/29/2020	03/31/2020	DY5 Q4
Task 3. Track identified measure(s) and milestones for each activity.	In Progress	Track identified measure(s) and milestones for each activity.	01/01/2016	03/29/2020	03/31/2020	DY5 Q4
Task 4. Create or modify data collection tool(s) and establish frequency for data collection.	In Progress	Create or modify data collection tool(s) and establish frequency for data collection.	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task 5. Collect data according to evaluation plan.	In Progress	Collect data according to evaluation plan.	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task 6. Analyze and report results.	In Progress	Analyze and report results.	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task 7. Review and share results with partners.	In Progress	Review and share results with partners	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task 8. Identify new objectives/activities.	In Progress	Identify new objectives/activities.	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Task 9. Implement new objectives/activities.	In Progress	Implement new objectives/activities.	01/01/2016	03/31/2020	03/31/2020	DY5 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

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

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Convene Mental Emotional and Behavioral (MEB) Health Promotion and Disorder Prevention Regional Partnership, Designate a CNYCC Representative, and Assist the Partnership to Develop a Strategic Plan that is Aligned with DSRIP and Project 4aiii	
Implement at Least Two Short-term and Two Long-term Objectives that are aligned with DSRIP Project 4aiii from the Prevention Partnership's Strategic Plan	
Conduct Annual Reviews of Objectives and Activities to Determine Progress and Selection of New objectives and Activities.	

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Central New York Care Collaborative, Inc. (PPS ID:8)

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

Instructions :

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

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project 4.d.i – Reduce premature births

IPQR Module 4.d.i.1 - PPS Defined Milestones

Instructions :

Please enter and update baseline target dates, as well as work breakdown tasks with target dates for PPS-defined milestones. For Domain 4 projects, these milestones must align with content submitted in the PPS Application.

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone Create methodology for consistent identification of high risk pregnancy to inform prenatal service referral protocol(s)	In Progress	Create methodology for consistent identification of high risk pregnancy to inform prenatal service referral protocol(s)	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1. Convene participating prenatal care providers and assess current high risk identification methodologies	In Progress	1. Convene participating prenatal care providers and assess current high risk identification methodologies	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Survey the best practice literature regarding identification of high risk pregnancy, especially for Medicaid patients if available	In Progress	2. Survey the best practice literature regarding identification of high risk pregnancy, especially for Medicaid patients if available	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. With representative workgroup of partners, draft high risk definition and link to appropriate levels of prenatal care services	In Progress	3. With representative workgroup of partners, draft high risk definition and link to appropriate levels of prenatal care services	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Present consensus document to clinical governance committee to review & approval	In Progress	4. Present consensus document to clinical governance committee to review & approval	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Training on: 5A's, presumptive eligibility, prenatal care standards and current guidelines on the management of preterm labor	In Progress	Training on: 5A's, presumptive eligibility, prenatal care standards and current guidelines on the management of preterm labor	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Assess and determine an approach to integrating or enhancing 1) tobacco & other substance screening and referral and 2) presumptive eligibility enrollment at participating	In Progress	1. Assess and determine an approach to integrating or enhancing 1) tobacco & other substance screening and referral and 2) presumptive eligibility enrollment at participating organizations/providers	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Central New York Care Collaborative, Inc. (PPS ID:8)

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
organizations/providers						
Task 2. Identify clinical providers and practices from PPS to be trained on tobacco & other substance screening and referral including the 5A's, such as FQHCs, health homes, private practices	In Progress	2. Identify clinical providers and practices from PPS to be trained on tobacco & other substance screening and referral including the 5A's, such as FQHCs, health homes, private practices	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Identify community providers and practices from PPS to be trained on tobacco & other substance screening and referral using the 5A's, such as home visiting, community health workers, WIC	In Progress	3. Identify community providers and practices from PPS to be trained on tobacco & other substance screening and referral using the 5A's, such as home visiting, community health workers, WIC	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Collaborate with regional Tobacco-Free Coalition(s),NYS Tobacco Control Program, and other substance abuse coalitions to coordinate and deliver clinical and community provider trainings on integrating tobacco & other substance screening and referral processes (per the 5As—Ask, Advise, Assess, Assist, and Arrange) into their scope of care/services targeting pregnant women who smoke	In Progress	4. Collaborate with regional Tobacco-Free Coalition(s),NYS Tobacco Control Program, and other substance abuse coalitions to coordinate and deliver clinical and community provider trainings on integrating tobacco & other substance screening and referral processes (per the 5As—Ask, Advise, Assess, Assist, and Arrange) into their scope of care/services targeting pregnant women who smoke	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Identify/define a list of entities PPS to target for training to become presumptive eligibility qualified entities (e.g., WIC, FQHCs, hospitals, homeless shelters)	In Progress	5. Identify/define a list of entities PPS to target for training to become presumptive eligibility qualified entities (e.g., WIC, FQHCs, hospitals, homeless shelters	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6. Train entities to become qualified entities/providers for Medicaid presumptive eligibility, specifically targeting pregnant women	In Progress	6. Train entities to become qualified entities/providers for Medicaid presumptive eligibility, specifically targeting pregnant women	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7. Review Medicaid prenatal care standards and clinical guidelines for preterm labor with participating providers to establish consensus minimum standards	In Progress	7. Review Medicaid prenatal care standards and clinical guidelines for preterm labor with participating providers to establish consensus minimum standards	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task	In Progress	8. Identify priority PPS providers/practices to implement consensus minimum	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Central New York Care Collaborative, Inc. (PPS ID:8)

Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
8. Identify priority PPS providers/practices to implement consensus minimum standards for prenatal care & preterm birth and engaged in learning collaboratives		standards for prenatal care & preterm birth and engaged in learning collaboratives				
Task 9. Engage model providers to support identified PPS providers/practices in the incorporation prenatal care and preterm birth standards and guidelines into practice	In Progress	9. Engage model providers to support identified PPS providers/practices in the incorporation prenatal care and preterm birth standards and guidelines into practice	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone Establish common resource and referral protocols and extend to include existing, new, and expanded programs	In Progress	Establish common resource and referral protocols and extend to include existing, new, and expanded programs	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Convene working group of partners, potentially across projects, to steer the initiative	In Progress	1. Convene working group of partners, potentially across projects, to steer the initiative	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Conduct resource mapping and develop an inventory of community and clinical providers, resources, and services available to support pregnant women	In Progress	2. Conduct resource mapping and develop an inventory of community and clinical providers, resources, and services available to support pregnant women	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Select and engage key/primary providers and organizations to be part of the initial referral network in which standard screening, referral, and information sharing practices are established across organizations/agencies	In Progress	3. Select and engage key/primary providers and organizations to be part of the initial referral network in which standard screening, referral, and information sharing practices are established across organizations/agencies	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Develop a standard referral process/protocol across organizations/agencies	In Progress	4. Develop a standard referral process/protocol across organizations/agencies	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4a Establish multi-agency/organization consent for release of information within the referral network (as appropriate)	In Progress	4a Establish multi-agency/organization consent for release of information within the referral network (as appropriate)	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4b Assess and define referral information sharing systems across the referral network (e.g., fax, EHR, other)	In Progress	4c Assess and define referral information sharing systems across the referral network (e.g., fax, EHR, other)	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task	In Progress	4d Develop a referral tracking process/system	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
4c Develop a referral tracking process/system						
Task 5. Implement the standard referral protocol across the initial referral network	In Progress	5. Implement the standard referral protocol across the initial referral network	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Conduct continuous quality improvement (e.g., PDSA cycles) to assess and refine the functioning and performance of the standard referral protocol in the initial referral network	In Progress	6. Conduct continuous quality improvement (e.g., PDSA cycles) to assess and refine the functioning and performance of the standard referral protocol in the initial referral network	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Revise the referral protocol as needed to improve efficiency and effectiveness	In Progress	7. Revise the referral protocol as needed to improve efficiency and effectiveness	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone Recruitment and establishment of a network of paraprofessionals	In Progress	Recruitment and establishment of a network of paraprofessionals	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 1. Define type of paraprofessionals to include in the network, including qualifications and competencies (e.g., community health workers, home visitors, home health aides)	In Progress	1. Define type of paraprofessionals to include in the network, including qualifications and competencies (e.g., community health workers, home visitors, home health aides)	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Assess existing paraprofessional workforce capacity within PPS organizations and agencies; identify additional capacity needed to ensure paraprofessional services are distributed throughout the PPS region	In Progress	2. Assess existing paraprofessional workforce capacity within PPS organizations and agencies; identify additional capacity needed to ensure paraprofessional services are distributed throughout the PPS region	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Identify organizations or programs to engage in partnerships and implement or expand paraprofessional capacity	In Progress	3. Identify organizations or programs to engage in partnerships and implement or expand paraprofessional capacity	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Support partner organizations and programs in recruiting additional paraprofessional capacity (e.g., coordinate recruitment partnerships)	In Progress	4. Support partner organizations and programs in recruiting additional paraprofessional capacity (e.g., coordinate recruitment partnerships)	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 5. Provide or coordinate trainings for PPS paraprofessionals to enhance knowledge and competencies to work with pregnant women	In Progress	5. Provide or coordinate trainings for PPS paraprofessionals to enhance knowledge and competencies to work with pregnant women (e.g., deliver basic health education, promote health care service use, and provide social support)	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
(e.g., deliver basic health education, promote health care service use, and provide social support)						
Milestone Expansion of CenteringPregnancy® and/or other innovated pregnancy education programs in areas where none currently exist	In Progress	Expansion of CenteringPregnancy® and/or other innovated pregnancy education programs in areas where none currently exist	09/30/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Identify and assess the availability of existing CenteringPregnancy® and other similar programs	In Progress	1. Identify and assess the availability of existing CenteringPregnancy® and other similar programs	09/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Gather lessons from the establishment and ongoing operation of the existing CenteringPregnancy® and similar programs	In Progress	2. Gather lessons from the establishment and ongoing operation of the existing CenteringPregnancy® and similar programs	09/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Identify and engage additional sites to expand/implement CenteringPregnancy® or similar programs where none currently exist or capacity does not meet demand	In Progress	3. Identify and engage additional sites to expand/implement CenteringPregnancy® or similar programs where none currently exist or capacity does not meet demand	09/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. For sites planning to implement CenteringPregnancy ®, coordinate with Centering Healthcare Institute to conduct an information seminar for the identified sites and other interested programs or organizations	In Progress	4. For sites planning to implement CenteringPregnancy ®, coordinate with Centering Healthcare Institute to conduct an information seminar for the identified sites and other interested programs or organizations	09/30/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Review program elements and assess site readiness and capacity to implement the CenteringPregnancy® or other similar programs	In Progress	5. Review program elements and assess site readiness and capacity to implement the CenteringPregnancy® or other similar programs	09/30/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6. Identify and establish a referral source or mechanism for recruiting women into the CenteringPregnancy® or other similar programs	In Progress	6. Identify and establish a referral source or mechanism for recruiting women into the CenteringPregnancy® or other similar programs	09/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7. Develop implementation plans responsive to site capacity and readiness for each site	In Progress	7. Develop implementation plans responsive to site capacity and readiness for each site	09/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8. Implement CenteringPregnancy® or other	In Progress	8. Implement CenteringPregnancy® or other similar programs at new sites	09/30/2016	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
similar programs at new sites						
Task 9. Conduct continuous quality improvement of CenteringPregnancy® and other similar programs at each site to assess and refine implementation (e.g., PDSA cycles to assess recruitment, enrollment, participant completion, etc.)	In Progress	9. Conduct continuous quality improvement of CenteringPregnancy® and other similar programs at each site to assess and refine implementation (e.g., PDSA cycles to assess recruitment, enrollment, participant completion, etc.)	09/30/2016	03/31/2018	03/31/2018	DY3 Q4
Task 10. For sites implementing CenteringPregnancy®, gain site approval establishing model fidelity and sustainability (see Centering Healthcare Institute website)	In Progress	10. For sites implementing CenteringPregnancy®, gain site approval establishing model fidelity and sustainability (see Centering Healthcare Institute website)	09/30/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone Establishment and integration of common intake and enrollment protocols, referral, follow-up, and coordination of practices, and integration into information technology platforms.	In Progress	Establishment and integration of common intake and enrollment protocols, referral, follow-up, and coordination of practices, and integration into information technology platforms.	08/04/2015	03/31/2020	03/31/2020	DY5 Q4
Task 1. With CNYCC HIT and RHIO staff and 4di participants including clinicians, review and inventory existing candidate HIT platforms within the PPS related to project requirements, including intake and enrollment, screening and risk assessment (e.g., tobacco, preterm birth), referral and follow-up,	In Progress	With CNYCC HIT and RHIO staff, review and inventory existing candidate HIT platforms within the PPS related to project requirements, including intake and enrollment, screening and risk assessment (e.g., tobacco, preterm birth), referral and follow-up,	08/04/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. With CNYCC HIT and RHIO staff and 4di participants including clinicians, review and inventory existing candidate PHM platforms for relevance to project requirement	In Progress	2. With CNYCC HIT and RHIO staff, review and inventory existing candidate PHM platforms for relevance to project requirement	08/04/2015	10/31/2015	12/31/2015	DY1 Q3
Task 3. With CNYCC HIT and RHIO staff and 4di participants including clinicians, develop a strategic plan for addressing the HIT needs of 4di and review with IT & Data Governance Committee for approval.	In Progress	3. With CNYCC HIT and RHIO staff and 4di participants including clinicians, develop a strategic plan for addressing the HIT needs of 4di and review with IT & Data Governance Committee for approval.	11/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	In Progress	4. Implement 4di HIT strategy with 4di participants and RHIO staff, with support from	01/01/2016	03/31/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
4. Implement 4di HIT strategy with 4di participants and RHIO staff, with support from CNYCC HIT staff		CNYCC HIT staff				
Task 5. On-going monitoring and improvement opportunities coordinated by CNYCC, the RHIO, and local perinatal health coalitions.	In Progress	5. On-going monitoring and improvement opportunities coordinated by CNYCC, the RHIO, and local perinatal health coalitions.	04/01/2018	03/31/2020	03/31/2020	DY5 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
Create methodology for consistent identification of high risk pregnancy to inform prenatal service referral protocol(s)	
Training on: 5A's, presumptive eligibility, prenatal care standards and current guidelines on the management of preterm labor	
Establish common resource and referral protocols and extend to include existing, new, and expanded programs	
Recruitment and establishment of a network of paraprofessionals	
Expansion of CenteringPregnancy® and/or other innovated pregnancy education programs in areas where none currently exist	
Establishment and integration of common intake and enrollment protocols, referral, follow-up, and coordination of practices, and integration into information technology platforms.	

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Central New York Care Collaborative, Inc. (PPS ID:8)

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

Instructions :

New York State Department Of Health
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Central New York Care Collaborative, Inc. (PPS ID:8)

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 'Central New York Care Collaborative, Inc. ', that all information provided on this Quarterly report is true and accurate to the best of my knowledge**.

Primary Lead PPS Provider:	UNIVERSITY HSP SUNY HLTH SC
Secondary Lead PPS Provider:	
Lead Representative:	Kristen Mucitelli
Submission Date:	09/24/2015 05:25 PM
Comments:	

New York State Department Of Health
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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q1	Submitted	Kristen Mucitelli	kristenh	09/24/2015 05:25 PM
DY1, Q1	Returned	Kristen Mucitelli	sv590918	09/08/2015 07:49 AM
DY1, Q1	Submitted	Kristen Mucitelli	kristenh	08/07/2015 07:28 PM
DY1, Q1	In Process		system	07/01/2015 12:12 AM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Returned	Please address the IA comments provided in the specific sections of your Implementation Plan during the remediation period.	sv590918	09/08/2015 07:49 AM

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Section	Module	Status
Section 01	IPQR Module 1.1 - PPS Budget Report	Completed
	IPQR Module 1.2 - PPS Flow of Funds	Completed
	IPQR Module 1.3 - Prescribed Milestones	Completed
	IPQR Module 1.4 - PPS Defined Milestones	Completed
	IPQR Module 1.5 - 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
	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

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Section	Module	Status
	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
	IPQR Module 7.6 - Key Stakeholders	Completed
	IPQR Module 7.7 - IT Expectations	Completed
	IPQR Module 7.8 - Progress Reporting	Completed

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Section	Module	Status
	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 - IA Monitoring	

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DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project ID	Module	Status
2.a.i	IPQR Module 2.a.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.a.i.2 - Project Implementation Speed	Completed
	IPQR Module 2.a.i.3 - Prescribed Milestones	Completed
	IPQR Module 2.a.i.4 - PPS Defined Milestones	Completed
	IPQR Module 2.a.i.5 - 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 - Project Implementation Speed	Completed
	IPQR Module 2.a.iii.3 - Patient Engagement Speed	Completed
	IPQR Module 2.a.iii.4 - Prescribed Milestones	Completed
	IPQR Module 2.a.iii.5 - PPS Defined Milestones	Completed
	IPQR Module 2.a.iii.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 2.b.iii.3 - Patient Engagement Speed	Completed
	IPQR Module 2.b.iii.4 - Prescribed Milestones	Completed
	IPQR Module 2.b.iii.5 - PPS Defined Milestones	Completed
	IPQR Module 2.b.iii.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 2.b.iv.3 - Patient Engagement Speed	Completed
	IPQR Module 2.b.iv.4 - Prescribed Milestones	Completed
	IPQR Module 2.b.iv.5 - PPS Defined Milestones	Completed
	IPQR Module 2.b.iv.6 - IA Monitoring	
2.d.i	IPQR Module 2.d.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 2.d.i.2 - Project Implementation Speed	Completed
	IPQR Module 2.d.i.3 - Patient Engagement Speed	Completed
	IPQR Module 2.d.i.4 - Prescribed Milestones	Completed
	IPQR Module 2.d.i.5 - PPS Defined Milestones	Completed

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

DSRIP Implementation Plan Project

Central New York Care Collaborative, Inc. (PPS ID:8)

Project ID	Module	Status
	IPQR Module 2.d.i.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 3.a.i.3 - Patient Engagement Speed	Completed
	IPQR Module 3.a.i.4 - Prescribed Milestones	Completed
	IPQR Module 3.a.i.5 - PPS Defined Milestones	Completed
	IPQR Module 3.a.i.6 - IA Monitoring	
3.a.ii	IPQR Module 3.a.ii.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.a.ii.2 - Project Implementation Speed	Completed
	IPQR Module 3.a.ii.3 - Patient Engagement Speed	Completed
	IPQR Module 3.a.ii.4 - Prescribed Milestones	Completed
	IPQR Module 3.a.ii.5 - PPS Defined Milestones	Completed
	IPQR Module 3.a.ii.6 - 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 - Project Implementation Speed	Completed
	IPQR Module 3.b.i.3 - Patient Engagement Speed	Completed
	IPQR Module 3.b.i.4 - Prescribed Milestones	Completed
	IPQR Module 3.b.i.5 - PPS Defined Milestones	Completed
	IPQR Module 3.b.i.6 - IA Monitoring	
3.g.i	IPQR Module 3.g.i.1 - Major Risks to Implementation and Mitigation Strategies	Completed
	IPQR Module 3.g.i.2 - Project Implementation Speed	Completed
	IPQR Module 3.g.i.3 - Patient Engagement Speed	Completed
	IPQR Module 3.g.i.4 - Prescribed Milestones	Completed
	IPQR Module 3.g.i.5 - PPS Defined Milestones	Completed
	IPQR Module 3.g.i.6 - IA Monitoring	
4.a.iii	IPQR Module 4.a.iii.1 - PPS Defined Milestones	Completed
	IPQR Module 4.a.iii.2 - IA Monitoring	
4.d.i	IPQR Module 4.d.i.1 - PPS Defined Milestones	Completed
	IPQR Module 4.d.i.2 - IA Monitoring	