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

DSRIP Implementation Plan Project

Millennium Collaborative Care (PPS ID:48)

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Quarterly Report - Implementation Plan for Millennium Collaborative Care

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

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	Completed
2.b.iii	ED care triage for at-risk populations	Completed
2.b.vii	Implementing the INTERACT project (inpatient transfer avoidance program for SNF)	Completed
2.b.viii	Hospital-Home Care Collaboration Solutions	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.f.i	Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)	Completed
4.a.i	Promote mental, emotional and behavioral (MEB) well-being in communities	Completed
4.d.i	Reduce premature births	Completed

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Section 01 – Budget

IPQR Module 1.1 - PPS Budget Report (Baseline)

Instructions :

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

Budget Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	30,318,631	32,309,696	52,248,833	46,266,142	30,318,631	191,461,931
Cost of Project Implementation & Administration	**15,332,744**	**23,504,354**	**34,926,881**	**30,570,359**	**30,098,173**	**134,432,511**
Implementation	9,814,656	19,047,633	30,461,057	26,233,423	25,631,736	111,188,505
Administration	5,518,088	4,456,721	4,465,824	4,336,936	4,466,437	23,244,006
Revenue Loss	**0**	**0**	**0**	**0**	**0**	**0**
Internal PPS Provider Bonus Payments	**1,096,410**	**1,038,663**	**11,227,715**	**9,594,947**	**1,274,220**	**24,231,955**
Cost of non-covered services	**1,529,064**	**6,825,266**	**10,157,399**	**9,140,480**	**5,145,258**	**32,797,467**
Other	**0**	**0**	**0**	**0**	**0**	**0**
Total Expenditures	**17,958,218**	**31,368,283**	**56,311,995**	**49,305,786**	**36,517,651**	**191,461,933**
Undistributed Revenue	**12,360,413**	**941,413**	**0**	**0**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

Miscellaneous was eliminated to move Revenue loss to 20% of total budget to further assist hospital members.

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 1.2 - PPS Budget Report (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
30,318,631	191,461,931	26,369,153	189,204,084

Budget Items	DY1 Q3 Quarterly Amount - Update	Cumulative Spending to Date (DY1 - DY5)	Remaining Balance in Current DY	Percent Remaining in Current DY	Cumulative Remaining Balance	Percent Remaining of Cumulative Balance
Cost of Project Implementation & Administration	**2,257,847**	**2,257,847**	**11,383,266**	**74.24%**	**132,174,664**	**98.32%**
Implementation	1,208,737					
Administration	1,049,110					
Revenue Loss	**0**	**0**	**0**		**0**	
Internal PPS Provider Bonus Payments	**0**	**0**	**1,096,410**	**100.00%**	**24,231,955**	**100.00%**
Cost of non-covered services	**0**	**0**	**1,529,064**	**100.00%**	**32,797,467**	**100.00%**
Other	**0**	**0**	**0**		**0**	
Total Expenditures	**2,257,847**	**2,257,847**				

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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IPQR Module 1.3 - PPS Flow of Funds (Baseline)

Instructions :

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

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

Funds Flow Items	DY1 ($)	DY2 ($)	DY3 ($)	DY4 ($)	DY5 ($)	Total ($)
Waiver Revenue	30,318,631	32,309,696	52,248,833	46,266,142	30,318,631	191,461,931
Practitioner - Primary Care Provider (PCP)	1,115,186	1,731,993	6,042,787	2,518,591	1,029,378	12,437,935
Practitioner - Non-Primary Care Provider (PCP)	205,331	235,348	1,507,201	1,459,010	1,167,422	4,574,312
Hospital	1,408,186	4,201,705	5,613,438	5,131,847	2,814,735	19,169,911
Clinic	0	370,464	555,518	499,877	351,798	1,777,657
Case Management / Health Home	7,037	13,083	2,810	1,447	596	24,973
Mental Health	479,742	1,066,778	2,377,416	2,154,070	1,687,540	7,765,546
Substance Abuse	34,860	104,579	69,719	69,719	69,719	348,596
Nursing Home	153,449	176,922	124,212	91,149	93,344	639,076
Pharmacy	0	0	0	0	0	0
Hospice	0	0	0	0	0	0
Community Based Organizations	544,533	1,779,780	2,907,305	2,665,578	2,394,220	10,291,416
All Other	0	0	0	0	0	0
PPS PMO	15,332,744	23,504,354	34,926,881	30,570,359	30,098,173	134,432,511
Total Funds Distributed	**19,281,068**	**33,185,006**	**54,127,287**	**45,161,647**	**39,706,925**	**191,461,933**
Undistributed Revenue	**11,037,563**	**0**	**0**	**1,104,495**	**0**	**0**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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IPQR Module 1.4 - PPS Flow of Funds (Quarterly)

Instructions :

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

Benchmarks

Waiver Revenue DY1	Total Waiver Revenue	Undistributed Revenue YTD	Undistributed Revenue Total
30,318,631	191,461,931	27,885,664	189,028,964

Funds Flow Items	DY1 Q3 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project										DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS											
			2.a.i	2.b.iii	2.b.vii	2.b.viii	2.d.i	3.a.i	3.a.ii	3.b.i	3.f.i	4.a.i	4.d.i	
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	0	1,115,186	12,437,935
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	0	205,331	4,574,312
Hospital	114,745	159,964	0	100	0	0	0	0	0	0	0	0	0	1,248,222	19,009,947
Clinic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1,777,657
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0	0	0	7,037	24,973
Mental Health	1,678	1,678	0	0	0	0	0	0	100	0	0	0	0	478,064	7,763,868
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	0	34,860	348,596
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	0	153,449	639,076
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospice	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Based Organizations	732,396	862,297	2.5	2.5	2.5	2.5	75	2.5	2.5	2.5	2.5	2.5	2.5	-317,764	9,429,119
All Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
PPS PMO	1,409,028	1,409,028	16	9.6	10	7.9	14.6	5.3	7.2	9.1	5.4	7.3	7.5	13,923,716	133,023,483
Total Funds Distributed	**2,257,847**	**2,432,967**													

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

Module Review Status

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

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IPQR Module 1.5 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Completed	Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Distribute assessment of DSRIP project impacts (prepared in connection with current state financial assessments) to MCC partners along with an explanation of the purpose of the matrix and how it will be used to finalize funds flow in determining expected impacts of DSRIP projects.	Completed	1. Distribute assessment of DSRIP project impacts (prepared in connection with current state financial assessments) to MCC partners along with an explanation of the purpose of the matrix and how it will be used to finalize funds flow in determining expected impacts of DSRIP projects.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Complete preliminary PPS budget for administration, implementation, revenue loss, and cost of services not covered.	Completed	2. Complete preliminary PPS budget for administration, implementation, revenue loss, and cost of services not covered.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Review provider-level projections of DSRIP impacts and costs submitted by MCC providers. During provider-specific budget processes, develop preliminary-final provider-level budgets including completion of provider-specific funds flow plans.	Completed	3. Review provider-level projections of DSRIP impacts and costs submitted by MCC providers. During provider-specific budget processes, develop preliminary-final provider-level budgets including completion of provider-specific funds flow plans.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Review the funds flow approach and distribution plan with drivers and requirements for each of the funds flow budget categories.	Completed	4. Review the funds flow approach and distribution plan with drivers and requirements for each of the funds flow budget categories.	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 5. Distribute funds flow approach and distribution plan to Finance Committee and MCC providers for review and input.	Completed	5. Distribute funds flow approach and distribution plan to Finance Committee and MCC providers for review and input.	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Amend plan to reflect input and obtain approval of plan by Finance Committee.	Completed	6. Amend plan to reflect input and obtain approval of plan by Finance Committee.	08/15/2015	12/31/2015	08/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Prepare PPS, provider, and project funds flow budgets based on budget review sessions with providers and submit said budgets to Finance Committee for approval. Incorporate these budgets into the Funds Flow Budget and Distribution Plan.	Completed	7. Prepare PPS, provider, and project funds flow budgets based on budget review sessions with providers and submit said budgets to Finance Committee for approval. Incorporate these budgets into the Funds Flow Budget and Distribution Plan.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Forward approved Funds Flow Budget and Distribution Plan to MCC partners and incorporate said plan and requirements to receive funds into MCC provider partner operating agreements.	Completed	8. Forward approved Funds Flow Budget and Distribution Plan to MCC partners and incorporate said plan and requirements to receive funds into MCC provider partner operating agreements.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 9. Distribute Funds Flow Budget and Distribution Plan; schedule DSRIP period close requirements; and forward expected funds distribution schedule to MCC provider partners.	Completed	9. Distribute Funds Flow Budget and Distribution Plan; schedule DSRIP period close requirements; and forward expected funds distribution schedule to MCC provider partners.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 10. Provide training sessions on Funds Flow Budget and Distribution Plan, related administrative requirements, schedules for reporting, and distribution of funds.	Completed	10. Provide training sessions on Funds Flow Budget and Distribution Plan, related administrative requirements, schedules for reporting, and distribution of funds.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Complete funds flow budget and distribution plan and communicate with network	ethelen	Other	48_MDL0103_1_3_20160316145133_BUDGET_01_Milestone_remediation_narrative.docx	Narrative and additional documentation supporting completion of Milestone 1. Several PDFs are embedded within the Word document. Double-click the icons to open these files.	03/16/2016 02:51 PM
	ethelen	Other	48_MDL0103_1_3_20160202120839_FF_01_deliverables.pdf	COVER PAGE: Describes documentation provided as evidence of completion of this milestone.	02/02/2016 12:08 PM
	ethelen	Meeting Materials	48_MDL0103_1_3_20160202120714_FF_01_02_Funds_Flow_Meetings_DY1Q3.xlsx	Funds flow, including related cost and revenue streams, were discussed at the meetings listed in this spreadsheet.	02/02/2016 12:07 PM
	ethelen	Other	48_MDL0103_1_3_20160202114921_FF_01_01_DSRIP_Budget_v12_7.xlsx	The DSRIP Budget spreadsheet supports the cost, budget, and funds flow calculations.	02/02/2016 11:49 AM
	ethelen	Other	48_MDL0103_1_3_20160202091529_FF_01_01_Project_Valuation_Budget.pdf	This file shows project-level budgets which were used to calculate funds flow.	02/02/2016 09:15 AM
	ethelen	Contracts and Agreements	48_MDL0103_1_3_20160202091303_FF_01_01_Master_Participation_Agreement_Exhibit_C.pdf	Exhibit C, which was customized for each partner and included with Master Participation Agreements (contracts) for DY1, communicated how much funding each partner was eligible for.	02/02/2016 09:13 AM
	ethelen	Other	48_MDL0103_1_3_20160202091200_FF_01_01_Funds_Flow_Calculations.xlsx	This spreadsheet shows the calculations used to determine funds flow for DY1.	02/02/2016 09:12 AM
	ethelen	Report(s)	48_MDL0103_1_3_20160202091049_FF_01_OMIG_Funds_Flow_Report_DY1Q3.xlsx	Supplemental funds flow report for OMIG	02/02/2016 09:10 AM

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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IPQR Module 1.6 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 1.7 - IA Monitoring

Instructions :

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Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1. Fill remaining open seats of the Board of Managers.	Completed	1. Fill remaining open seats of the Board of Managers.	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Obtain Board of Managers approval of timetable for governance milestones, including identifying committees, populating committees, and finalizing committee charters.	Completed	2. Obtain Board of Managers approval of timetable for governance milestones, including identifying committees, populating committees, and finalizing committee charters.	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Finalize name, role, and reporting structure of each Committee (to be approved by Board of Managers).	Completed	3. Finalize name, role, and reporting structure of each Committee (to be approved by Board of Managers).	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. Populate committees by taking nominations from Board members for committee membership, seeking outside expertise where necessary.	Completed	4. Populate committees by taking nominations from Board members for committee membership, seeking outside expertise where necessary.	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Completed	This milestone must be completed by 12/31/2015. Clinical Quality Committee charter and committee structure chart	05/26/2015	12/31/2015	05/26/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Establish the role, duties, and reporting structure of the Clinical/Quality Committee (to be	Completed	1. Establish the role, duties, and reporting structure of the Clinical/Quality Committee (to be memorialized in a Committee Charter).	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
memorialized in a Committee Charter).									
Task 2. Include behavioral health providers and administrators from across the region on the Clinical/Quality Committee and the Board of Managers.	Completed	2. Include behavioral health providers and administrators from across the region on the Clinical/Quality Committee and the Board of Managers.	07/15/2015	09/30/2015	07/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Use the "Voice of the Consumer" Sub-Committee as an advisory body.	Completed	3. Use the "Voice of the Consumer" Sub-Committee as an advisory body.	05/26/2015	09/30/2015	05/26/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. To ensure patient, family, and peer representation beyond an advisory role, assign one member of the "Voice of the Consumer" Sub-Committee to be a member of the Board of Managers (with voting rights).	Completed	4. To ensure patient, family, and peer representation beyond an advisory role, assign one member of the "Voice of the Consumer" Sub-Committee to be a member of the Board of Managers (with voting rights).	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Establish work groups of the Clinical/Quality Committee for DSRIP projects that require specific focus of the Committee.	Completed	5. Establish work groups of the Clinical/Quality Committee for DSRIP projects that require specific focus of the Committee.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6. Finalize membership of Clinical/Quality Committee.	Completed	6. Finalize membership of Clinical/Quality Committee.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Populate Clinical/Quality work groups.	Completed	7. Populate Clinical/Quality work groups.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Completed	This milestone must be completed by 9/30/2015. Upload of bylaws and policies document or committee guidelines.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task 1. The Governance Committee will be instrumental in facilitating adoption of PPS bylaws, committee charters, and PPS policies. The Governance Committee will report to the Board regularly during this phase on milestone progress.	Completed	1. The Governance Committee will be instrumental in facilitating adoption of PPS bylaws, committee charters, and PPS policies. The Governance Committee will report to the Board regularly during this phase on milestone progress.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Allow ex officio status for the Board of Managers Chair and MCC Executive Director.	Completed	2. Allow ex officio status for the Board of Managers Chair and MCC Executive Director.	07/15/2015	09/30/2015	07/15/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 3. Legal counsel, in consultation with PPS executive leadership, will draft Bylaws for initial review by Governance Committee and Compliance Committee.	Completed	3. Legal counsel, in consultation with PPS executive leadership, will draft Bylaws for initial review by Governance Committee and Compliance Committee.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 4. Governance and Compliance Committee review of draft Bylaws complete.	Completed	4. Governance and Compliance Committee review of draft Bylaws complete.	08/01/2015	09/30/2015	08/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Finalize Bylaws and present to Board of Managers for approval.	Completed	5. Finalize Bylaws and present to Board of Managers for approval.	08/31/2015	09/30/2015	08/31/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6. Prepare Committee organizational chart showing reporting structure, roles, and responsibilities.	Completed	6. Prepare Committee organizational chart showing reporting structure, roles, and responsibilities.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7. Committee leaders, legal counsel, and dedicated members of Governance Committee will prepare Committee and Sub-Committee Charters for review by full Governance and Compliance Committees.	Completed	7. Committee leaders, legal counsel, and dedicated members of Governance Committee will prepare Committee and Sub-Committee Charters for review by full Governance and Compliance Committees.	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 8. Finalize Committee Charters and present to Board of Managers for approval.	Completed	8. Finalize Committee Charters and present to Board of Managers for approval.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4 Establish governance structure reporting and monitoring processes	Completed	This milestone must be completed by 12/31/2015. Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Draft Governance Operating Model which will define reporting and governance monitoring processes.	Completed	1. Draft Governance Operating Model which will define reporting and governance monitoring processes.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Establish procedures for committees and advisory entities to provide routine, ongoing reporting to the Board of Managers. This will include (but not be limited to) submitting formal	Completed	2. Establish procedures for committees and advisory entities to provide routine, ongoing reporting to the Board of Managers. This will include (but not be limited to) submitting formal meeting minutes to the Board of Managers for review/approval.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
meeting minutes to the Board of Managers for review/approval.									
Task 3. Establish procedures for the Board of Managers to provide routine, ongoing reporting to committees and advisory entities. This will include (but not be limited to) the Board of Managers reviewing and adopting charters that clearly describe the roles and objectives of each entity.	Completed	3. Establish procedures for the Board of Managers to provide routine, ongoing reporting to committees and advisory entities. This will include (but not be limited to) the Board of Managers reviewing and adopting charters that clearly describe the roles and objectives of each entity.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Finalize Governance Operating Model.	Completed	4. Finalize Governance Operating Model.	07/01/2015	12/31/2015	07/01/2015	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.	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1. Establish a CBO Task Force to serve in an advisory role to the Board of Managers. Charter/mission statement will be approved by the Board of Managers.	Completed	1. Establish a CBO Task Force to serve in an advisory role to the Board of Managers. Charter/mission statement will be approved by the Board of Managers.	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Populate CBO Task Force by conducting outreach at community forums across PPS region and receiving nominations for CBO representatives. Ensure representation from all eight counties of WNY. Board of Managers will approve membership of CBO Task Force.	Completed	2. Populate CBO Task Force by conducting outreach at community forums across PPS region and receiving nominations for CBO representatives. Ensure representation from all eight counties of WNY. Board of Managers will approve membership of CBO Task Force.	06/15/2015	09/30/2015	06/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Charge the CBO Task Force with the responsibility of assisting in the development and implementation of a multi-year plan to provide two-way communication and engagement with public agencies, community-based groups, and provider organizations.	In Progress	3. Charge the CBO Task Force with the responsibility of assisting in the development and implementation of a multi-year plan to provide two-way communication and engagement with public agencies, community-based groups, and provider organizations.	06/15/2015	06/30/2016	06/15/2015	06/30/2016	06/30/2016	DY2 Q1	
Task	In Progress	4. Utilize the 211 resource directory to identify and engage a	06/15/2015	06/30/2016	06/15/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
4. Utilize the 211 resource directory to identify and engage a wide range of public and private sector organizations including schools, churches, homeless services, housing providers, and law enforcement/corrections.		wide range of public and private sector organizations including schools, churches, homeless services, housing providers, and law enforcement/corrections.							
Task 5. Using a grassroots approach, faith-based organizations and specialty groups will identify barriers to care and develop strategies to overcome them. Identify unique needs of sub-populations (immigrants, etc.).	In Progress	5. Using a grassroots approach, faith-based organizations and specialty groups will identify barriers to care and develop strategies to overcome them. Identify unique needs of sub-populations (immigrants, etc.).	09/30/2015	06/30/2016	09/30/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Establish a "Voice of the Consumer" Sub-Committee made up of Medicaid beneficiaries to serve in an advisory role to the Board of Managers. Charter/mission statement will be approved by the Board of Managers.	Completed	6. Establish a "Voice of the Consumer" Sub-Committee made up of Medicaid beneficiaries to serve in an advisory role to the Board of Managers. Charter/mission statement will be approved by the Board of Managers.	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7. Populate "Voice of the Consumer" Sub-Committee by conducting outreach at community forums and receiving nominations for Medicaid beneficiaries. Board of Managers will approve membership of Sub-Committee.	Completed	7. Populate "Voice of the Consumer" Sub-Committee by conducting outreach at community forums and receiving nominations for Medicaid beneficiaries. Board of Managers will approve membership of Sub-Committee.	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 8. Engage the stakeholder community through various communications and media outlets (e.g., regular appearances on radio and television talk shows). Use these channels and develop networks to explain DSRIP initiatives to WNY residents.	In Progress	8. Engage the stakeholder community through various communications and media outlets (e.g., regular appearances on radio and television talk shows). Use these channels and develop networks to explain DSRIP initiatives to WNY residents.	05/15/2015	06/30/2016	05/15/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 9. MCC Director of Community-Based Initiatives will draft Community Engagement Plan. Plan will be developed in conjunction with the Agency Coordination Plan (milestone #7).	In Progress	9. MCC Director of Community-Based Initiatives will draft Community Engagement Plan. Plan will be developed in conjunction with the Agency Coordination Plan (milestone #7).	09/30/2015	03/31/2016	09/30/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 10. CBO Task Force will organize and host a	In Progress	10. CBO Task Force will organize and host a series of informational and activation forums at three different sites with	05/26/2015	03/31/2016	05/26/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
series of informational and activation forums at three different sites with WNY to elicit input and participation from public and provider organizations in DSRIP project activities.		WNY to elicit input and participation from public and provider organizations in DSRIP project activities.							
Task 11. Revise Community Engagement Plan based on input and feedback gathered from community forums. Provide final draft to Board of Managers for review.	In Progress	11. Revise Community Engagement Plan based on input and feedback gathered from community forums. Provide final draft to Board of Managers for review.	11/01/2015	06/30/2016	11/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 12. Obtain Board of Managers approval on Community Engagement Plan.	Not Started	12. Obtain Board of Managers approval on Community Engagement Plan.	05/30/2016	06/30/2016	05/30/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1. Obtain attestations from all organizations planning to participate in DSRIP initiatives with MCC.	In Progress	1. Obtain attestations from all organizations planning to participate in DSRIP initiatives with MCC.	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Obtain letters of intent (LOIs) from attested CBOs to further define participation commitments. LOIs will outline, at a high level, expectations and obligations (e.g., participation in various assessments).	In Progress	2. Obtain letters of intent (LOIs) from attested CBOs to further define participation commitments. LOIs will outline, at a high level, expectations and obligations (e.g., participation in various assessments).	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Issue RFPs for services to be performed by attested CBOs who have submitted an LOI, including (but not limited to) cultural competency and health literacy training, patient activation coaching, community health worker coordination, and other services in connection with specific DSRIP projects.	In Progress	3. Issue RFPs for services to be performed by attested CBOs who have submitted an LOI, including (but not limited to) cultural competency and health literacy training, patient activation coaching, community health worker coordination, and other services in connection with specific DSRIP projects.	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Negotiate contracts/participation agreements with CBOs who are awarded work based on RFP process.	In Progress	4. Negotiate contracts/participation agreements with CBOs who are awarded work based on RFP process.	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
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.	10/15/2015	06/30/2016	10/15/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1. Draft Agency Coordination Plan for engaging agencies in MCC initiatives. Plan will be developed in conjunction with the Community Engagement Plan (milestone #5).	In Progress	1. Draft Agency Coordination Plan for engaging agencies in MCC initiatives. Plan will be developed in conjunction with the Community Engagement Plan (milestone #5).	10/15/2015	06/30/2016	10/15/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Prepare a comprehensive booklet that describes DSRIP projects, cites specific project locations by municipality, and provides project coordinator contact information for each project.	In Progress	2. Prepare a comprehensive booklet that describes DSRIP projects, cites specific project locations by municipality, and provides project coordinator contact information for each project.	10/15/2015	06/30/2016	10/15/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Hold first in a series of information and activation workshops with public sector agencies at state, county and municipal levels (including but not limited to Health Foundation of Western and Central New York, OASAS regional office, OPWDD regional office, County Mental Health Departments/Offices; County Departments of Social Services, County Offices for the Aging to explain how they can connect with DSRIP projects and activities and refer individuals to services. These forums will also be used to elicit input on the draft Agency Coordination Plan.	In Progress	3. Hold first in a series of information and activation workshops with public sector agencies at state, county and municipal levels (including but not limited to Health Foundation of Western and Central New York, OASAS regional office, OPWDD regional office, County Mental Health Departments/Offices; County Departments of Social Services, County Offices for the Aging to explain how they can connect with DSRIP projects and activities and refer individuals to services. These forums will also be used to elicit input on the draft Agency Coordination Plan.	10/15/2015	06/30/2016	10/15/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Revise Agency Coordination Plan based on input and feedback gathered from public sector agency forums. Provide final draft to Board of Managers for review.	Not Started	4. Revise Agency Coordination Plan based on input and feedback gathered from public sector agency forums. Provide final draft to Board of Managers for review.	03/01/2016	06/30/2016	03/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Obtain Board of Managers approval on Agency Coordination Plan.	Not Started	5. Obtain Board of Managers approval on Agency Coordination Plan.	05/30/2016	06/30/2016	05/30/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #8 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).	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task 1. Convene a Workforce Development Work Group representing MCC, AHEC, ECMCC, HR department leads from facilities, labor unions, NYS Department of Labor, Project Advisory Committee, and IT Data Committee (for reporting guidance).	Completed	1. Convene a Workforce Development Work Group representing MCC, AHEC, ECMCC, HR department leads from facilities, labor unions, NYS Department of Labor, Project Advisory Committee, and IT Data Committee (for reporting guidance).	06/01/2015	09/30/2015	06/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. The MCC PPS will review and update the list of key stakeholders engaged in the development of the workforce strategy and implementation plan. This group includes stakeholders such as management, project team members, employees, AHEC, labor representatives, academic providers, community members, and employees.	In Progress	2. The MCC PPS will review and update the list of key stakeholders engaged in the development of the workforce strategy and implementation plan. This group includes stakeholders such as management, project team members, employees, AHEC, labor representatives, academic providers, community members, and employees.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Workforce Development Work Group will collaborate with the "Voice of Consumer" Sub-Committee to draft a preliminary workforce communication plan (a component of MCC's overall communication strategy).	In Progress	3. Workforce Development Work Group will collaborate with the "Voice of Consumer" Sub-Committee to draft a preliminary workforce communication plan (a component of MCC's overall communication strategy).	09/15/2015	03/31/2016	09/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. The MCC PPS will, in partnership with the above mentioned stakeholders, review the communication channels available, solicit additional opportunities and conduct a preliminary assessment of effectiveness of each resource for workforce engagement.	In Progress	4. The MCC PPS will, in partnership with the above mentioned stakeholders, review the communication channels available, solicit additional opportunities and conduct a preliminary assessment of effectiveness of each resource for workforce engagement.	09/15/2015	03/31/2016	09/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. The MCC PPS will develop a workforce communication and engagement strategy which addresses the vision, objectives, and guiding	In Progress	5. The MCC PPS will develop a workforce communication and engagement strategy which addresses the vision, objectives, and guiding principles of the strategy as a means for engaging key stakeholders.	10/15/2015	03/31/2016	10/15/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
principles of the strategy as a means for engaging key stakeholders.									
Task 6. The MCC PPS will further develop the strategy into a draft Workforce Communication and Engagement Plan which will describe objectives, pinpoint target audiences(s), determine required resources, and serve as a mechanism for measuring the effectiveness of the communication plan.	In Progress	6. The MCC PPS will further develop the strategy into a draft Workforce Communication and Engagement Plan which will describe objectives, pinpoint target audiences(s), determine required resources, and serve as a mechanism for measuring the effectiveness of the communication plan.	12/15/2015	03/31/2016	12/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Hold a series of information and activation workshops with workforce stakeholders identified by the Workforce Development Work Group to explain how they can connect with DSRIP projects and opportunities. These forums will be used to elicit input on the draft Workforce Communication and Engagement Plan.	In Progress	7. Hold a series of information and activation workshops with workforce stakeholders identified by the Workforce Development Work Group to explain how they can connect with DSRIP projects and opportunities. These forums will be used to elicit input on the draft Workforce Communication and Engagement Plan.	10/15/2015	06/30/2016	10/15/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 8. Revise Workforce Communication and Engagement Plan based on input and feedback gathered from forums. Provide final draft to Board of Managers for review.	Not Started	8. Revise Workforce Communication and Engagement Plan based on input and feedback gathered from forums. Provide final draft to Board of Managers for review.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 9. The Board of Managers or its delegate will review and approve the Workforce Communication and Engagement plan and review and respond to subsequent quarterly updates.	Not Started	9. The Board of Managers or its delegate will review and approve the Workforce Communication and Engagement plan and review and respond to subsequent quarterly updates.	05/01/2016	06/30/2016	05/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #9 Inclusion of CBOs in PPS Implementation.	In Progress	Explain your plans for contracting with CBOs and their continuing role as your PPS develops over time; detail how many CBOs you will be contracting with and by when; explain how they will be included in project delivery and in the development of your PPS network.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Obtain attestations/letters of intent from CBOs wishing to participate in MCC projects and	In Progress	1. Obtain attestations/letters of intent from CBOs wishing to participate in MCC projects and activities.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
activities.									
Task 2. CBO Task Force will facilitate CBO involvement in MCC's projects and activities and track and monitor this involvement.	In Progress	2. CBO Task Force will facilitate CBO involvement in MCC's projects and activities and track and monitor this involvement.	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 3. Use RFP process to select and contract with CBOs to serve as cultural competency and health literacy trainers/champions.	Completed	3. Use RFP process to select and contract with CBOs to serve as cultural competency and health literacy trainers/champions.	07/01/2015	10/31/2015	07/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task 4. Use RFP process to select and contract with CBOs to lead patient activation services in connection with project 2.d.i. (Patient Activation). The selected CBOs will likely represent the geographical areas within the PPS (North, Central, and South sub-regions).	Completed	4. Use RFP process to select and contract with CBOs to lead patient activation services in connection with project 2.d.i. (Patient Activation). The selected CBOs will likely represent the geographical areas within the PPS (North, Central, and South sub-regions).	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Use RFP process to select and contract with CBOs to provide community health worker services, supervision, and training in connection with projects 3.f.i. and 4.d.i. (Support for Maternal and Child Health, Reduce Premature Births).	Completed	5. Use RFP process to select and contract with CBOs to provide community health worker services, supervision, and training in connection with projects 3.f.i. and 4.d.i. (Support for Maternal and Child Health, Reduce Premature Births).	06/18/2015	12/31/2015	06/18/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. CBO Task Force will establish processes and procedures for continuous monitoring and reporting on CBO participation, and for pinpointing new and evolving opportunities for CBO engagement.	Not Started	6. CBO Task Force will establish processes and procedures for continuous monitoring and reporting on CBO participation, and for pinpointing new and evolving opportunities for CBO engagement.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

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

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	ethelen	Rosters	48_MDL0203_1_3_20160203085343_GV_01_02_Governance_Committee_Members_DY1Q3_update.xlsx	Updated committee roster reflects a few changes in committee membership	02/03/2016 08:53 AM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	ethelen	Other	48_MDL0203_1_3_20160202141249_GV_02_deliverables.pdf	COVER PAGE: Describes documentation provided as evidence of completion of this milestone	02/02/2016 02:12 PM
	ethelen	Other	48_MDL0203_1_3_20160202141101_GV_02_03_Clinical_Quality_Committee_Charter.pdf	The charter for the Clinical Quality Committee	02/02/2016 02:11 PM
	ethelen	Meeting Materials	48_MDL0203_1_3_20160202135937_GV_02_04_Clinical_Quality_Committee_Meetings_DY1Q3.xlsx	Spreadsheet listing meetings of the Clinical Quality Committee	02/02/2016 01:59 PM
	ethelen	Rosters	48_MDL0203_1_3_20160202135518_GV_02_02_Clinical_Quality_Committee_Members_DY1Q3.xlsx	Spreadsheet listing the members of the Clinical Quality Committee and their roles	02/02/2016 01:55 PM
	ethelen	Other	48_MDL0203_1_3_20160202135433_GV_02_01_Clinical_Quality_Committee_Org_Chart.pdf	Organizational chart for the Clinical Quality Committee	02/02/2016 01:54 PM
Establish governance structure reporting and monitoring processes	ethelen	Other	48_MDL0203_1_3_20160316153427_Millennium_governance_operating_model_Q3.pptx	Descriptions and examples of Millennium's reporting and monitoring processes	03/16/2016 03:34 PM
	ethelen	Other	48_MDL0203_1_3_20160316151541_Millennium_SSP_Overview_v2_03-10-16.docx	This file belongs with IT Milestone 5 but could not be added to that module because of the 10-file limit.	03/16/2016 03:15 PM
	ethelen	Other	48_MDL0203_1_3_20160316150818_GV_04_Milestone_remediation_narrative.pdf	COVER PAGE (3/16): Explains Millennium's response to IA feedback	03/16/2016 03:08 PM
	ethelen	Other	48_MDL0203_1_3_20160202142149_GV_04_deliverables.pdf	COVER PAGE: Describes documentation provided as evidence of completion of this milestone	02/02/2016 02:21 PM
	ethelen	Other	48_MDL0203_1_3_20160202142048_GV_Committee_Charters.pdf	Many of the required elements for Governance & Committee Structure Reporting & Monitoring are included in committee charters	02/02/2016 02:20 PM
	ethelen	Other	48_MDL0203_1_3_20160202141807_GV_01_Resolution.pdf	Millennium's governance org chart is included as Attachment A	02/02/2016 02:18 PM
	ethelen	Policies/Procedures	48_MDL0203_1_3_20160202141607_GV_03_Governance_Agreement.pdf	Millennium's Governance Agreement contains many of the required elements for Governance & Committee Structure Reporting & Monitoring	02/02/2016 02:16 PM

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	There were a few changes in committee membership. A new roster has been included.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	
Finalize bylaws and policies or Committee Guidelines where applicable	No changes
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.	

Milestone Review Status

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

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IPQR Module 2.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

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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.

Given time constraints of Board of Managers members (many of whom administer healthcare facilities), there is a compelling need to ensure that board meetings are run effectively. Committee reports and reports on process and clinical performance outcomes must be formatted in a manner that will not only allow extensive reporting on all PPS organizational and project components, but also permit board members to readily pinpoint issues that need to be resolved. Use of color-coding, standardized presentation formats, and brief narrative explaining results will grow in importance, particularly as the number of measures to report on increases over time.

A second challenge pertains to maintaining a high level of involvement by board members. One way to meet this objective is to ensure that participation in board and committee meetings results in learning experiences that can be adapted by board members to their own facilities. It will be important to provide continuing education opportunities to board members both inside and outside the context of structured board and committee meetings.

A third risk involves communications. One of the key challenges confronting a PPS is to educate the entire community about DSRIP. Failure to educate the community will hinder the success of the PPS and dilute outcomes. At present, relatively few people in the community have an understanding of the objectives and desired results of DSRIP. As community and healthcare activists, board members are best suited to drive the communication plan and evaluate its effectiveness. They can do so by involving board members from PPS partner institutions in the DSRIP process, closely monitoring the extent to which communication activities and timelines adhere to the overall communication plan, encouraging the active involvement of Medicaid beneficiaries in DSRIP proceedings and affairs, and periodically reviewing survey results which aim to measure the community's level of understanding of the wide-sweeping DSRIP initiative.

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.)

Effective governance of the PPS is dependent upon the success of all other workstreams:

Workforce development will require innovative approaches for retraining inpatient workers for emerging community-based healthcare careers, for filling primary care gaps, and for integrating physical with behavioral health at service sites throughout WNY. All of these workforce development dependencies (among others) must be aligned to meet DSRIP objectives, and the Board of Managers will be responsible for overseeing this work.

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An IT infrastructure is the backbone of all DSRIP projects, providing the platform for recording, reporting, and analyzing all process and performance outcome measures that must be monitored by and responded to by the Board of Managers.

Clinical Integration will serve as the foundation for ensuring that standardized evidence-based procedures are used to conduct multiple projects at multiple sites. Clinical integration will drive performance, and the board's effectiveness will be dependent upon it.

Maximizing Practitioner Engagement through training and education is another important dependency. Active participation by clinicians is not only essential for meeting DSRIP objectives, but it is also a prerequisite for spearheading innovation that is instrumental to meeting the Triple Aims of improving the patient experience of care, improving the health of the population, and reducing the per capita cost of care.

Active patient engagement is perhaps the most critical factor that will determine the success of the governing board and the entire DSRIP project in WNY. The overwhelming majority of Medicaid beneficiaries are challenged by poor housing, lack of nutritious food, lack of transportation, and unsafe neighborhoods. Engaging these patients in healthcare in the face of these issues will be the biggest challenge confronted by the MCC PPS. The Board of Managers—and the entire organization—will need to prioritize cultural competency and health literacy training, push for the overwhelming success of the patient activation project (2.d.i.), ensure that Medicaid beneficiaries themselves play a meaningful role in PPS operations, and see to it that CBOs that serve Medicaid beneficiaries are a vital part of the DSRIP agenda.

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IPQR Module 2.5 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
Lead entity	Erie County Medical Center Corporation (ECMCC)	Ensure all governance is in place and functioning to support community projects
MCC executive management	Led by Al Hammonds, Jr. CSSBB (Executive Director)	Provide overall leadership for PPS partners and activities; ensure governance strategy is established and followed
MCC Board of Managers	Chair: Anne Constantino	Facilitate key decisions; lead, develop, and audit/monitor projects
Finance Committee	Richard Braun, Mel Dyster, Colleen Muncy, Mike Sammarco, Chris Koenig, Raj Mehta, Lou Santiago, Christine Kemp, Gregory Turner, Sheila Kee, Kathrine Panzarella	Oversee PPS budget and funds flow; ensure financial strategy/operations align with DSRIP goals
Clinical/Quality Committee	Co-chairs: Michael Cummings MD (UBMD Psychiatry); Joanne Haefner FNP (Neighborhood Health Center)	Provide guidance and oversight for 11 MCC projects; develop clinical metrics and processes to support accountability for project outcomes
Family/caretaker support/representation	"Voice of the Consumer" Sub-Committee member: Tasha Moore (Community Health Worker and Medicaid beneficiary)	Serve as a voting member of the Board of Managers; represent Medicaid beneficiaries and their caretakers/families

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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		
CBO Task Force	Advisory	Lead and develop meaningful community engagement
"Voice of the Consumer" Sub-Committee	Advisory	Capture patients' expectations, preferences, and aversions
Workforce Development Work Group	Advisory	Develop and coordinate overall workforce transformation strategy
External Stakeholders		
Attested CBOs	Advisory	Ensure governance supports DSRIP protocols
Health plans, managed care organizations	Value-based payment reform	Develop committee to support payment reform
Legislators	Regulatory waivers	Support regulatory change; remove barriers to collaboration
NYS DOH	Regulatory oversight	Ensure all laws and regulations are adhered to
NYS Office of Mental Health	Regulatory oversight	Ensure behavioral health regulations are followed; adhere to necessary mandates
OASAS	Regulatory oversight	Ensure all substance abuse laws are adhered to
OPWDD	Regulatory oversight	Ensure patients with developmental and intellectual disabilities are represented
Office of Children and Family Services (OCFS)	Regulatory oversight	Ensure children- and family-related laws are maintained

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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.

Committees will communicate utilizing a communication forum developed by IT. Each committee will have dashboards and reporting requirements. A portal on the MCC website will be created for governance, and governance documents will be uploaded as they are approved. The portal will also be used to communicate with the community about the organization of the PPS, and to publish committee meeting schedules and agendas, minutes, and membership rosters as appropriate. A two-way communication system will also be set up for resolving grievances.

We plan to use a cloud-based suite of applications to support communication with, and collaboration among, members of the PPS. This solution includes conferencing and group messaging across the organization. Additional CRM and project management components are currently being evaluated as adjuncts to the existing infrastructure. A cloud-based solution offers the scalability, extensibility, and functionality required for an agile, efficient organization.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

The Governance Committee will regularly report to the Board of Managers on progress in achieving governance milestones. The progress will be measured against the timetable adopted by the Board. Success will be measured initially by finalizing Board of Manager appointments and staffing the committees and sub-committees. For each committee, charters will be drafted, reviewed, and adopted, and reporting and monitoring processes will be defined.

Quarterly reports will describe (but not be limited to):

Changes or updates to committee rosters/charters/by-laws, organizational structure, and policies
Partnership agreements/contracts with CBOs
Agency coordination plan for engaging public sector agencies
The progress/success of these efforts geared towards community engagement and public sector outreach and education will be measured in terms of:
Engagement with the community
Evidence of implementation of the community engagement plan
Community engagement events

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Workforce communication and engagement plan

IPQR Module 2.9 - IA Monitoring

Instructions :

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Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Establish the financial structure of the MCC PPS using a detailed workflow/organizational chart and seek and obtain MCC Board of Managers approval of the PPS financial structure.	Completed	1. Establish the financial structure of the MCC PPS using a detailed workflow/organizational chart and seek and obtain MCC Board of Managers approval of the PPS financial structure.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Construct and convey to MCC partners a finance organizational chart depicting MCC financial functions and duties, including those performed internally and those conducted by contracted accounting firm. Duties cover procurement and payables (purchasing and disbursements); treasury (cash and investment management); financial and operational reporting; compliance; contracting; internal auditing; network communications; provider operating agreements; funds flow and distribution; lead value-based payment (VBP) transition; decision support (receipt of data and data analytics); provider financial health assessments; etc.	Completed	2. Construct and convey to MCC partners a finance organizational chart depicting MCC financial functions and duties, including those performed internally and those conducted by contracted accounting firm. Duties cover procurement and payables (purchasing and disbursements); treasury (cash and investment management); financial and operational reporting; compliance; contracting; internal auditing; network communications; provider operating agreements; funds flow and distribution; lead value-based payment (VBP) transition; decision support (receipt of data and data analytics); provider financial health assessments; etc.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	3. Establish a charter that defines the functions and	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
3. Establish a charter that defines the functions and responsibilities of the Finance Committee and all sub-committees under the charge of the Finance Committee (e.g. VBP Sub-Committee) and obtain Board of Managers approval.		responsibilities of the Finance Committee and all sub-committees under the charge of the Finance Committee (e.g. VBP Sub-Committee) and obtain Board of Managers approval.							
Task 4. Construct a flowchart depicting internal and external reporting requirements of and reporting flow to and from: a) Finance/Board of Managers b) Finance/other governing board committees c) Finance/project leads (domain 1 process milestone reporting and domain 2 and 3 reporting) d) Finance/workstreams (IT, workforce, clinical integration, etc.) e) VBP Sub-Committee f) Compliance Officer g) MCC partners h) Annual/quarterly financial health reporting i) NYS DOH j) Other stakeholders	Completed	4. Construct a flowchart depicting internal and external reporting requirements of and reporting flow to and from: a) Finance/Board of Managers b) Finance/other governing board committees c) Finance/project leads (domain 1 process milestone reporting and domain 2 and 3 reporting) d) Finance/workstreams (IT, workforce, clinical integration, etc.) e) VBP Sub-Committee f) Compliance Officer g) MCC partners h) Annual/quarterly financial health reporting i) NYS DOH j) Other stakeholders	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 5. Prepare written policies and procedures describing all financial functions and duties of the MCC PPS, its Finance Committee, and all finance-related sub-committees.	Completed	5. Prepare written policies and procedures describing all financial functions and duties of the MCC PPS, its Finance Committee, and all finance-related sub-committees.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 6. Prepare written policies and procedures defining all finance-related reporting requirements.	Completed	6. Prepare written policies and procedures defining all finance-related reporting requirements.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 7. Establish a schedule for regular Finance Committee meetings.	Completed	7. Establish a schedule for regular Finance Committee meetings.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 8. Conduct re-evaluation of finance duties and responsibilities and reporting requirements; make	Completed	Conduct re-evaluation of finance duties and responsibilities and reporting requirements; make revisions, as required.	10/02/2015	12/31/2015	10/02/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
revisions, as required.									
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	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task 1. Develop measurement tool to evaluate financial health of MCC network partners utilizing indicators such as cash on hand, debt ratio, operating margin, and current ratio.	In Progress	1. Develop measurement tool to evaluate financial health of MCC network partners utilizing indicators such as cash on hand, debt ratio, operating margin, and current ratio.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2. Establish financial stability plan which includes policies and procedures to: define what providers are subject to annual financial health assessment; mandate completion of an annual assessment of all such providers; describe metrics and the process to be used for conducting the financial health assessment; explain how annual assessments will be conducted; and require reporting of financial stability plan results to Finance Committee and MCC Board of Managers.	In Progress	2. Establish financial stability plan which includes policies and procedures to: define what providers are subject to annual financial health assessment; mandate completion of an annual assessment of all such providers; describe metrics and the process to be used for conducting the financial health assessment; explain how annual assessments will be conducted; and require reporting of financial stability plan results to Finance Committee and MCC Board of Managers.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Develop distressed provider plans to monitor financially fragile providers. Require that all Interim Access Assurance Fund (IAAF) providers and any provider that does not pass the financial health test be surveyed quarterly using the financial health measurement methodology.	In Progress	3. Develop distressed provider plans to monitor financially fragile providers. Require that all Interim Access Assurance Fund (IAAF) providers and any provider that does not pass the financial health test be surveyed quarterly using the financial health measurement methodology.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Task 4. In developing a distressed provider plan, MCC will: (a) utilize a standard set of metrics/template for evaluating a financially fragile provider; (b) utilize prescribed procedures to evaluate metrics: (c) implement a Distressed Provider Plan for financially fragile providers; (d) report quarterly to Finance Committee and MCC Board of Managers on providers in the network that are financially fragile (including those that have qualified as IAAF providers); (e) ensure future quarterly reports provide an update on the financial status of those providers identified as financially fragile; (f) make any additions to the Financially Fragile Watch list, as appropriate; (g) describe the efforts undertaken to improve the financial status of these providers.	In Progress	4. In developing a distressed provider plan, MCC will: (a) utilize a standard set of metrics/template for evaluating a financially fragile provider; (b) utilize prescribed procedures to evaluate metrics: (c) implement a Distressed Provider Plan for financially fragile providers; (d) report quarterly to Finance Committee and MCC Board of Managers on providers in the network that are financially fragile (including those that have qualified as IAAF providers); (e) ensure future quarterly reports provide an update on the financial status of those providers identified as financially fragile; (f) make any additions to the Financially Fragile Watch list, as appropriate; (g) describe the efforts undertaken to improve the financial status of these providers.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. The financial health policies and procedures will be reviewed and approved by the Finance Committee and MCC Board of Managers.	Completed	5. The financial health policies and procedures will be reviewed and approved by the Finance Committee and MCC Board of Managers.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Develop matrix of DSRIP projects and identify expected impact on provider costs, patient volumes, revenue, length of stay, and other factors based upon project goals and participation.	In Progress	6. Develop matrix of DSRIP projects and identify expected impact on provider costs, patient volumes, revenue, length of stay, and other factors based upon project goals and participation.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Review draft of project impact matrix with Finance Committee.	In Progress	7. Review draft of project impact matrix with Finance Committee.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8. Finalize project impact matrix identifying provider participation in projects, expected impact on participating providers, and other provider-specific information.	In Progress	8. Finalize project impact matrix identifying provider participation in projects, expected impact on participating providers, and other provider-specific information.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 9. Review and obtain approval of project impact	In Progress	9. Review and obtain approval of project impact matrix by Finance Committee and MCC Board of Managers.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	

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matrix by Finance Committee and MCC Board of Managers.									
Task 10. Prepare/update financial assessments and project impact assessments of MCC providers to include required metrics and provider-specific metrics.	In Progress	10. Prepare/update financial assessments and project impact assessments of MCC providers to include required metrics and provider-specific metrics.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 11. Distribute current financial assessment and project impact assessment documents to providers.	In Progress	11. Distribute current financial assessment and project impact assessment documents to providers.	10/02/2015	12/31/2015	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 12. Review results of current state financial assessments and project impact assessments that are returned by MCC providers.	Not Started	12. Review results of current state financial assessments and project impact assessments that are returned by MCC providers.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 13. Prepare report of MCC provider current financial status for review by Finance Committee and MCC Board of Managers.	Not Started	13. Prepare report of MCC provider current financial status for review by Finance Committee and MCC Board of Managers.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 14. Based upon the results of the financial assessments and the project impact assessments, identify providers that are (a) not meeting financial plan metrics, (b) undergoing existing or planned restructuring, or will be financially challenged; and (c) place financially challenged providers on initial financially fragile watch list.	In Progress	14. Based upon the results of the financial assessments and the project impact assessments, identify providers that are (a) not meeting financial plan metrics, (b) undergoing existing or planned restructuring, or will be financially challenged; and (c) place financially challenged providers on initial financially fragile watch list.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 15. Obtain approval of the financially fragile watch list by the Finance Committee.	In Progress	15. Obtain approval of the financially fragile watch list by the Finance Committee.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 16. Adopt policies and procedures to describe the role of the MCC Project Management Office (PMO) and the measures the PMO will take to manage the financial stability plan and the distressed provider plans on behalf of MCC and	In Progress	16. Adopt policies and procedures to describe the role of the MCC Project Management Office (PMO) and the measures the PMO will take to manage the financial stability plan and the distressed provider plans on behalf of MCC and ECMCC.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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ECMCC.									
Task 17. Implement PMO oversight for financial stability plan and distressed provider plans.	In Progress	17. Implement PMO oversight for financial stability plan and distressed provider plans.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Place compliance functions under the purview of a Compliance Committee.	Completed	1. Place compliance functions under the purview of a Compliance Committee.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Prepare charter of Compliance Committee duties and responsibilities and obtain approval of Compliance Committee charter by MCC Board of Managers.	Completed	2. Prepare charter of Compliance Committee duties and responsibilities and obtain approval of Compliance Committee charter by MCC Board of Managers.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Appoint members to Compliance Committee.	Completed	3. Appoint members to Compliance Committee.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Design MCC Compliance Plan to ensure that it addresses all provisions of Section 363-d.	Completed	4. Design MCC Compliance Plan to ensure that it addresses all provisions of Section 363-d.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Define operational policies and procedures to implement MCC Compliance Plan requirements.	Completed	5. Define operational policies and procedures to implement MCC Compliance Plan requirements.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Present Compliance Plan to Finance Committee for approval and subsequently obtain approval by Board of Managers.	Completed	6. Present Compliance Plan to Finance Committee for approval and subsequently obtain approval by Board of Managers.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Establish compliance reporting dashboard and reporting plan and adhere to regular compliance reporting to Finance Committee and MCC Board of Managers.	Completed	7. Establish compliance reporting dashboard and reporting plan and adhere to regular compliance reporting to Finance Committee and MCC Board of Managers.	10/02/2015	12/31/2015	10/02/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES

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Task 1. Establish VBP Sub-Committee to lead the formulation of a multi-year VBP transition plan: appoint representatives from finance, legal, medical staff, executive leadership, and others to VBP Sub-Committee.	Completed	1. Establish VBP Sub-Committee to lead the formulation of a multi-year VBP transition plan: appoint representatives from finance, legal, medical staff, executive leadership, and others to VBP Sub-Committee.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Develop comprehensive description of the roles, responsibilities, and functions of the VBP Sub-Committee, including, but not limited to: educate partners; establish and maintain working relationships with Medicaid Managed Care Organizations (MCOs) (monthly meeting schedule, agenda setting, etc.); select external consultant(s) to assist sub-committee; develop multi-year strategic plan to meet 90% VBP contracting goal; determine bi-directional data sharing needs between MCC and MCOs; devise process for tracking performance against guideposts in plan; etc.	Completed	2. Develop comprehensive description of the roles, responsibilities, and functions of the VBP Sub-Committee, including, but not limited to: educate partners; establish and maintain working relationships with Medicaid Managed Care Organizations (MCOs) (monthly meeting schedule, agenda setting, etc.); select external consultant(s) to assist sub-committee; develop multi-year strategic plan to meet 90% VBP contracting goal; determine bi-directional data sharing needs between MCC and MCOs; devise process for tracking performance against guideposts in plan; etc.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Finance Committee and Board of Managers will approve a charter outlining responsibilities and functions of VBP Sub-Committee.	In Progress	3. Finance Committee and Board of Managers will approve a charter outlining responsibilities and functions of VBP Sub-Committee.	07/01/2015	12/31/2015	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. With assistance from the communication team, develop an easy-to-understand educational tool for explaining NYS DOH's VBP goals, summarizing the state's VBP roadmap, explaining the various types and levels of VBP contract approaches, describing how VBP contracts can drive additional revenues to PCPs, etc.	In Progress	4. With assistance from the communication team, develop an easy-to-understand educational tool for explaining NYS DOH's VBP goals, summarizing the state's VBP roadmap, explaining the various types and levels of VBP contract approaches, describing how VBP contracts can drive additional revenues to PCPs, etc.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. Develop plan for integrating VBP educational tool into MCC's communication plan, including placement of tool on MCC website, direct	In Progress	5. Develop plan for integrating VBP educational tool into MCC's communication plan, including placement of tool on MCC website, direct distribution to PPS providers, etc.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
distribution to PPS providers, etc.									
Task 6. Design plan to assess readiness and willingness of providers in PPS network to engage in various levels of VBP contracting, including development of provider assessment instrument; in-person outreach sessions in various communities of WNY to address inquiries from providers; analysis of responses; and presentation of findings to MCOs.	In Progress	6. Design plan to assess readiness and willingness of providers in PPS network to engage in various levels of VBP contracting, including development of provider assessment instrument; in-person outreach sessions in various communities of WNY to address inquiries from providers; analysis of responses; and presentation of findings to MCOs.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Formulate draft assessment instrument which poses a variety of questions to providers that include, but are not limited to: a) whether provider has previously engaged in some form of VBP contracting; b) readiness of provider to engage in VBP contracting c) provider's financial ability to assume risk and enter into risk-sharing arrangements d) annual Medicaid revenues by provider and by MCO e) number of Medicaid beneficiaries served by provider by specific MCO plan f) amount of payments providers receive from existing VBP contracts or from preferred compensation modalities g) types of VBP Medicaid contracts in effect (e.g. bundled payments, pay for Patient-Centered Medical Home (PCMH) outcome performance, risk-sharing, etc.) h) provider preferences for negotiating plan options (e.g., as a single provider negotiating directly with MCO or as a group of providers within the PPS) i) whether provider serves any special populations (e.g., developmentally disabled)	In Progress	7. Formulate draft assessment instrument which poses a variety of questions to providers that include, but are not limited to: a) whether provider has previously engaged in some form of VBP contracting; b) readiness of provider to engage in VBP contracting c) provider's financial ability to assume risk and enter into risk-sharing arrangements d) annual Medicaid revenues by provider and by MCO e) number of Medicaid beneficiaries served by provider by specific MCO plan f) amount of payments providers receive from existing VBP contracts or from preferred compensation modalities g) types of VBP Medicaid contracts in effect (e.g. bundled payments, pay for Patient-Centered Medical Home (PCMH) outcome performance, risk-sharing, etc.) h) provider preferences for negotiating plan options (e.g., as a single provider negotiating directly with MCO or as a group of providers within the PPS) i) whether provider serves any special populations (e.g., developmentally disabled) j) providers' concerns and issues relating to transitioning to a VBP system	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
j) providers' concerns and issues relating to transitioning to a VBP system									
Task 8. Have assessment tool reviewed for completeness by external consultant.	In Progress	8. Have assessment tool reviewed for completeness by external consultant.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 9. Distribute assessment survey to provider population along with information explaining the importance of the survey and why provider participation in survey is important.	In Progress	9. Distribute assessment survey to provider population along with information explaining the importance of the survey and why provider participation in survey is important.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 10. To explain assessment tool and encourage participation in VBP survey, organize and hold provider outreach sessions and conduct informational sessions in connection with medical staff meetings, medical society meetings, professional society meetings, etc.	In Progress	10. To explain assessment tool and encourage participation in VBP survey, organize and hold provider outreach sessions and conduct informational sessions in connection with medical staff meetings, medical society meetings, professional society meetings, etc.	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 11. Upon completion of training, the assessment tool will be electronically sent to MCC providers, who will complete assessment by email. MCC Finance staff will develop a worksheet to aggregate the responses of individual providers. Data capturing will include recording for each provider: total Medicaid Fee for Service and payer-specific MCO revenues; delineation of the types of VBP contracts currently in effect (e.g. bundled payments, shared savings, etc.) and the types of services they cover (inpatient, outpatient, medical/surgical, psychiatry, etc.); the amount and percentage of total revenues derived by a provider from VBP contract provisions; calculation of the amount of Medicaid Managed Care revenues that would be covered by the application of the 90% VBP goal; and determination of the gap between Medicaid Managed Care revenues currently covered by	Not Started	11. Upon completion of training, the assessment tool will be electronically sent to MCC providers, who will complete assessment by email. MCC Finance staff will develop a worksheet to aggregate the responses of individual providers. Data capturing will include recording for each provider: total Medicaid Fee for Service and payer-specific MCO revenues; delineation of the types of VBP contracts currently in effect (e.g. bundled payments, shared savings, etc.) and the types of services they cover (inpatient, outpatient, medical/surgical, psychiatry, etc.); the amount and percentage of total revenues derived by a provider from VBP contract provisions; calculation of the amount of Medicaid Managed Care revenues that would be covered by the application of the 90% VBP goal; and determination of the gap between Medicaid Managed Care revenues currently covered by the providers and the 90% VBP target. Given the complexity of the assessment, conferences between MCC Finance personnel and providers would be held to verify responses. The results of the assessment will be reported to the governing board in the aggregate. The assessment will	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
VBP contract provisions and the 90% VBP target. Given the complexity of the assessment, conferences between MCC Finance personnel and providers would be held to verify responses. The results of the assessment will be reported to the governing board in the aggregate. The assessment will provide valuable baseline data for developing a comprehensive VBP roadmap for MCC.		provide valuable baseline data for developing a comprehensive VBP roadmap for MCC.							
Task 12. Analyze state's most up-to-date VBP Roadmap and other related materials to determine all elements that need to be included in MCO strategy for transforming to a VBP system.	In Progress	12. Analyze state's most up-to-date VBP Roadmap and other related materials to determine all elements that need to be included in MCO strategy for transforming to a VBP system.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 13. Incorporate assessment and other findings in a written MCO strategy that is presented to and approved by Finance Committee and Board of Managers.	In Progress	13. Incorporate assessment and other findings in a written MCO strategy that is presented to and approved by Finance Committee and Board of Managers.	10/02/2015	03/31/2016	10/02/2015	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	Not Started	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	YES
Task 1. VBP Sub-Committee will compile a set of principles to guide development of multi-year strategic plan to transition to a system that has 90% of Medicaid payment under a VBP system. Such principles shall include but not be limited to: - Provision of technical assistance to providers - Opportunities for both payers and providers to share savings generated if agreed-upon benchmarks are achieved - Phased-in three-year approach to permit providers to successfully transition to VBP system	Not Started	1. VBP Sub-Committee will compile a set of principles to guide development of multi-year strategic plan to transition to a system that has 90% of Medicaid payment under a VBP system. Such principles shall include but not be limited to: - Provision of technical assistance to providers - Opportunities for both payers and providers to share savings generated if agreed-upon benchmarks are achieved - Phased-in three-year approach to permit providers to successfully transition to VBP system - Assurance that quality goals of VBP payment plans match those of MCC - Rewards for both improved performance as well as continued high performance	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
- Assurance that quality goals of VBP payment plans match those of MCC - Rewards for both improved performance as well as continued high performance									
Task 2. PPS will reach out to PPS providers at meetings and conference calls to solicit provider input on the best approach for attaining VBP goal and to build collaboration and consensus among providers for determining strategies for contracting with MCOs.	Not Started	2. PPS will reach out to PPS providers at meetings and conference calls to solicit provider input on the best approach for attaining VBP goal and to build collaboration and consensus among providers for determining strategies for contracting with MCOs.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 3. Finance Committee and Board of Managers will approve principles governing VBP transition plan.	Not Started	3. Finance Committee and Board of Managers will approve principles governing VBP transition plan.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 4. Working in concert with MCOs, determine VBP options that will be made available to providers. For example, bundled payments for episodic care; payments for continuous care to persons with chronic disease; VBP plans for serving special populations (e.g., developmentally disabled); population health related VBP initiatives that focus on overall outcomes and total cost of care; specific risk-sharing arrangements, etc.	Not Started	4. Working in concert with MCOs, determine VBP options that will be made available to providers. For example, bundled payments for episodic care; payments for continuous care to persons with chronic disease; VBP plans for serving special populations (e.g., developmentally disabled); population health related VBP initiatives that focus on overall outcomes and total cost of care; specific risk-sharing arrangements, etc.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 5. Work to secure MCO–provider contract arrangements that follow a similar set of rules and conditions to reduce administrative burden; standardize definitions involving PCMH care, integrated care, care bundles, and risk-adjustment methodologies; outcomes that correspond with DSRIP metrics; standard risk-adjusted measures; and clear definitions of attributed Medicaid lives.	Not Started	5. Work to secure MCO–provider contract arrangements that follow a similar set of rules and conditions to reduce administrative burden; standardize definitions involving PCMH care, integrated care, care bundles, and risk-adjustment methodologies; outcomes that correspond with DSRIP metrics; standard risk-adjusted measures; and clear definitions of attributed Medicaid lives.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task	Not Started	6. Conduct an environmental scan of issues that may impede	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
6. Conduct an environmental scan of issues that may impede the transition to VBP system, including, but not limited to: healthcare IT capabilities of both providers and MCOs; availability of systems to monitor providers' VBP performance; lack of experience in VBP contracting by both providers and MCOs; etc.		the transition to VBP system, including, but not limited to: healthcare IT capabilities of both providers and MCOs; availability of systems to monitor providers' VBP performance; lack of experience in VBP contracting by both providers and MCOs; etc.							
Task 7. Using assessment data, Salient data, and MCO provider-specific data, identify which providers and PCMHs have the capacity to expeditiously engage in VBP contracting.	Not Started	7. Using assessment data, Salient data, and MCO provider-specific data, identify which providers and PCMHs have the capacity to expeditiously engage in VBP contracting.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 8. Place providers and PCMHs in one of three VBP readiness rankings (advanced, moderate, or low) based on results of assessment, Salient data, and MCO provider-specific data.	Not Started	8. Place providers and PCMHs in one of three VBP readiness rankings (advanced, moderate, or low) based on results of assessment, Salient data, and MCO provider-specific data.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 9. For each provider grouping (advanced, moderate, low), set forth a possible transition plan covering years 3, 4, and 5 of DSRIP. For example, a moderate ranked hospital provider in DY3 could engage in level 1 VBP (FFS with upside only shared savings); transition to level 2 VBP (FFS with upside and downside risk sharing) in DY4 ; and in DY5 enter into global capitation contracts.	Not Started	9. For each provider grouping (advanced, moderate, low), set forth a possible transition plan covering years 3, 4, and 5 of DSRIP. For example, a moderate ranked hospital provider in DY3 could engage in level 1 VBP (FFS with upside only shared savings); transition to level 2 VBP (FFS with upside and downside risk sharing) in DY4 ; and in DY5 enter into global capitation contracts.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 10. Facilitate engagement sessions between advanced providers and MCOs to discuss requirements and process of engaging in VBP contracting.	Not Started	10. Facilitate engagement sessions between advanced providers and MCOs to discuss requirements and process of engaging in VBP contracting.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 11. Work with moderate and low ranked provider groups to set forth transition pathways and to assist them in contracting with MCOs. Objective is to ensure that all providers are engaged in	Not Started	11. Work with moderate and low ranked provider groups to set forth transition pathways and to assist them in contracting with MCOs. Objective is to ensure that all providers are engaged in some level of a VBP contract by DY3.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	

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some level of a VBP contract by DY3.									
Task 12. Work in concert with MCOs to provide value-based benefit designs that incentivize patients to engage in wellness programs, stop smoking, follow care plans etc.	Not Started	12. Work in concert with MCOs to provide value-based benefit designs that incentivize patients to engage in wellness programs, stop smoking, follow care plans etc.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 13. Finalize VBP transition pathways for DY3, DY4, and DY5 for low, moderate, and advanced ranked providers.	Not Started	13. Finalize VBP transition pathways for DY3, DY4, and DY5 for low, moderate, and advanced ranked providers.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 14. Submit VBP Transition plan to MCC providers for their review and to obtain their feedback.	Not Started	14. Submit VBP Transition plan to MCC providers for their review and to obtain their feedback.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 15. Make any necessary amendments to the VBP Transition Plan and submit plan to providers for their adoption.	Not Started	15. Make any necessary amendments to the VBP Transition Plan and submit plan to providers for their adoption.	10/03/2016	12/31/2016	10/03/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 16. Submit VBP Transition Plan to Finance Committee and Board of Managers for review and approval.	Not Started	16. Submit VBP Transition Plan to Finance Committee and Board of Managers for review and approval.	10/03/2016	12/31/2016	10/03/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 17. Make provisions to update the status of the VBP transition plan on a quarterly basis.	Not Started	17. Make provisions to update the status of the VBP transition plan on a quarterly basis.	10/03/2016	12/31/2016	10/03/2016	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	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES
Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has	On Hold		04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	YES

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to be in Level 2 VBPs or higher									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize PPS finance structure, including reporting structure	ethelen	Other	48_MDL0303_1_3_20160202101749_FS_01_deliverables.pdf	COVER PAGE: Describes documentation provided as evidence of completion of this milestone.	02/02/2016 10:17 AM
	ethelen	Policies/Procedures	48_MDL0303_1_3_20160202101626_FS_01_01_Finance_structure.pdf	An organizational chart specifically depicting finance functions within the PPS was presented to the Board of Managers on September 21, 2015.	02/02/2016 10:16 AM
	ethelen	Policies/Procedures	48_MDL0303_1_3_20160202101534_GV_01_Resolution.pdf	A one-page resolution, adopted by MCC Board of Managers on September 21, 2015, includes Millennium's governance organizational chart and rosters for committees and sub-committees.	02/02/2016 10:15 AM
	ethelen	Meeting Materials	48_MDL0303_1_3_20160202101419_2015-09-21_MCC_Board_of_Managers_minutes.pdf	PPS Board approval of the various committees (org chart and rosters) is recorded on page 7 of the meeting minutes.	02/02/2016 10:14 AM
	ethelen	Meeting Materials	48_MDL0303_1_3_20160202101006_FF_01_02_Funds_Flow_Meetings_DY1Q3.xlsx	The list of funds flow-meetings includes all meetings of the Finance Committee.	02/02/2016 10:10 AM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	ethelen	Documentation/Certification	48_MDL0303_1_3_20160202155431_FS_03_01_Compliance_Program_Certification_Confirmations.pdf	Copies of certification confirmations from OMIG	02/02/2016 03:54 PM
	ethelen	Other	48_MDL0303_1_3_20160202112432_FS_03_deliverables.pdf	COVER PAGE: Describes documentation provided as evidence of completion of this milestone.	02/02/2016 11:24 AM
	ethelen	Policies/Procedures	48_MDL0303_1_3_20160202112304_FS_03_01_Millennium_Compliance_Program.pdf	Millennium Collaborative Care's Compliance Program	02/02/2016 11:23 AM

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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.	Task 5 is complete, and other tasks are progressing as expected.
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	The VBP Sub-Committee was established during Q3, and the group will meet during Q4 to finalize its charter.
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

Milestone Review Status

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

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IPQR Module 3.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Reduction in hospitalizations (overall goal of DSRIP projects) will result in revenue losses for hospitals due to decreased utilization. Skilled nursing facilities will also experience a drop in revenue. The shift to VBP will be important for the long-term sustainability of these facilities in spite of reduced utilization. MCC will implement bundled payments, shared savings models, and other VBP approaches to ensure providers can continue to operate beyond the five years of the Waiver.

Difficulty in engaging the payers. The Medicaid MCOs seem reluctant to engage with the PPS and are taking a "wait and see" approach since they will reap the benefits of the DSRIP delivery model whether they actively participate or not. Many of the enhanced services described in the projects (e.g., care coordination, peer navigation, crisis stabilization) are not consistently billed, coded, or reimbursed under current models. Without involvement and investment from the major payers and Medicaid MCOs, providers won't be able to afford to offer enhanced and expanded services. This will make it impossible to earn achievement values for implementation and engagement. Request support from NYS DOH urging payers to participate in DSRIP initiatives. Collaborate with payers on VBP structures, reporting practices, and metrics. The Finance Committee will constantly communicate with the Medicaid MCOs as an attempt to actively engage them in the process. The PPS may require assistance or intervention from NYS DOH with some payers. Several DSRIP projects provide case/care management services to many kinds of patients (e.g., chronic diseases, pregnant women); these services will augment the payers' existing programs, allowing them to benefit from healthier members without adding to their care management staff.

Insufficient DSRIP revenue stream. Lack of revenues could impact project performance and lead to disinterest by providers. Educate providers that VBP is a long-term solution for achieving financial sustainability that is not dependent on DSRIP revenues.

Partners' inability to provide data or reluctance to share data. Inability to access data or validate analytics. Constant communication with the partners who are unable or unwilling to provide data. Communications will explain the rationale and necessity for data sharing to meet project goals and metrics, and will ultimately impact or inhibit the flow of funds to PPS partners who are most in need. Appropriate security and privacy policies will be established and enforced across the PPS. Partners will be involved in the establishment of these policies, to encourage widespread buy-in.

PPS providers are not compliant with PPS provider agreements and reporting requirements. Reporting requirements are overwhelming or unclear to providers. If providers do not fulfill their reporting requirements, performance levels across the PPS will suffer. Provide timely and clear communication with and among PPS stakeholders. Offer simple, easy-to-follow instructions and training sessions. Conduct test runs of reporting and data functions to meet quarterly and semi-annual reporting.

Reports are confusing, and PPS participants don't look at them. To create a reporting culture throughout MCC, all stakeholders will need an easy, clear means for understanding whether targets are being met or not. Simplify this process for partners.

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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.)

Finance Committee members will be actively engaged with all PPS committees and project leaders. The finance function will need to understand the requirements and participation level for all projects, project performance measurement and reporting, and project costs and impacts. Finance team members will also actively participate in clinical discussions related to PPS projects.

The IT Systems & Processes workstream is dependent on Financial Sustainability: Once providers have adopted the technologies required under DSRIP, the costs do not go away. It will be important that providers are able to meet the continuing costs of additional and updated IT assets. As security and privacy regulations grow in complexity and scope, the costs of maintaining a secure system that shares data and meets regulatory/confidentiality requirements will only increase. Finance will also support access to data regarding project performance, platform integration, and Rapid Cycle Evaluation.

Governance: Well-defined roles and responsibilities for the PPS lead, partners, and in particular for finance, compliance, and audit, will need to be established. Financial sustainability will be necessary to maintain a governance structure for continued improvements and common goals with the Medicaid populations in the future post-DSRIP transformation.

Workforce: The finance team will need to understand the workforce strategy and plans, as well as related transition costs. Finance will support the tracking of costs and impact on full-time equivalents, compare actual to projected, and define how workforce spending will be tracked/reported to PPS and DOH.

Performance Reporting: The analytics software used for DSRIP needs to be available and maintained by the lead entity. It needs to have software upgrades and be available for continued use by the practices for continued performance reporting and quality needs.

Provider Engagement: Ongoing community-wide provider engagement for the Medicaid population is critical. Financial Sustainability needs to be linked to improvement in outcomes ongoing. Financial sustainability will be affected by continuation of a community-wide forum. With new alliances being formed, the hope is they will continue to expand and flourish with a new sense of purpose.

Population Health Management: Population health management and stratification of registries is not possible without robust clinical analytic software. The financial sustainability of this is tied with performance reporting and ongoing management of the software.

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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
Project managers for each project	Priti Bangia, Tammy Fox, Catherine Lewis, Sandy McDougal, Saralin Tiedeman, Andrea Wanat, Don Vincent, Kim Backey, Janet Stoeckl, Annie Deaver	Develop implementation and operational budgets necessary for project success
MCC Director of Finance	Kathrine Panzarella	Manage finance functions of the PPS; oversee receipt, distribution, and safekeeping of DSRIP funds; hold responsibility for reporting, both externally to NYS DOH and other regulatory bodies, and internally to the governing committee and work groups
Accounting Manager	Tronconi Segarra & Associates	Develop infrastructure for finance office including general ledger, accounts payable, and payroll functions
Accounts Payable	Tronconi Segarra & Associates	Day-to-day accounts payable function, including obtaining approval of invoices, processing for payment, check printing, and reporting
Payroll	PPC Strategic Services LLC; Grider Support Services LLC	Payroll processing function, including timekeeping, obtaining approval for payment, processing payroll, check distribution, and reporting
MCC Compliance Officer	Laura Fleming	Oversee compliance programs of PPS activities, including adherence to the compliance requirements of the lead entity
Audit	McGladrey, LLP	Perform audits according to standard accounting principles
Value-Based Payment (VBP) subject matter expertise	VBP Sub-Committee (Kristen Davis, Mel Dyster, Sheila Kee, Mike Sammarco)	Develop VBP Transition Plan; oversee implementation of the plan
Health plans	Christine Blidy (Blue Cross Blue Shield); Anthony Montagna (Independent Health); Carla D'Angelo (YourCare); John Place (Fidelis Care)	Establish VBP partnership with MCC; submit claims accounting for payment reconciliation

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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		
Tronconi Segarra & Associates	Accounting firm contracted by MCC	Financial management and auditing
Finance Committee (Richard Braun, Mel Dyster, Colleen Muncy, Mike Sammarco, Chris Koenig, Raj Mehta, Lou Santiago, Christine Kemp, Gregory Turner, Sheila Kee, Kathrine Panzarella)	Oversight and direction	Review/approve MCO Strategy for VBP Transition and VBP Transition Plan; ensure VBP initiatives are aligned to DSRIP goals; review, approve and monitor implementation of financial stability plan, distressed provider plan, project impact matrix, and financially fragile watch list
Board of Managers (chair: Anne Constantino)	Oversight	Review/approve VBP Transition Plan; monitor and audit fiscal operations; resolve conflicts; adopt Finance Committee charter; adopt financial stability plan; adopt distressed provider plan; review and approve project impact matrix; approve financially fragile watch list; adopt MCO Strategy for VBP Transition
MCC Finance Director (Kathrine Panzarella)	Lead implementation	Management and distribution of project funds; oversee all financial operations of PPS; oversee implementation of financial stability plan, and distressed provider plan; continually update financial status of providers; monitor financially fragile watch list; ensure sound financial reporting
Executive leadership and board members of provider partners (Andrew Boser, Timothy Finan, Clare Haar, Mary Hoffman, Sheila Kee, Norma Kerling, Kristin Kight, Cheryl Klass, Joseph Ruffolo, Thomas Quatroche, Michael Whyte, Christopher Lane, Allegra Jaros, Richard Braun)	Oversight and participation in decision-making	Stay involved in financial activities of MCC PPS; actively participate in development of VBP Plan; as appropriate, report on financial status of their institutions and on efforts to improve financial performance
External Stakeholders		
McGladrey, LLP	External audit	Perform audit of PPS financial operation including internal controls and financial reporting
Brigida Scholten and Allison Shelton (KPMG)	Liaison	Serve as liaison between NYS DOH and PPS; provide updates on NYS DOH expectations and deliverables
Community representatives: Susan Barlow, Ellen Breslin, Kerri Brown, Lucy Candelario, Mindy	Provider partners and representatives	Regular, timely, effective communication with community groups and organizations

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Cervoni, William Covington, Mary Craig, Charlotte Crawford, Robert DeBereaux, Ricardo Herrera, Diann Holt, Traci Hopkins, Anna Ireland, Dee Johnson, George Kennedy, Pattie Kepner, Robyn Krueger, Keith Lindsay, Robert Lowery, Francesca Mesiah, Jack Norton, Kinzer Pointer, Marcia Restivo, Ezra Scott, Suzanne Shears, Grace Tate, Lesley Thompson-Farrell, Charles Walker II, Ava White, Carrie Whitwood, Lynn Wir		
Health foundations/grant coalitions: Health Foundation for Western and Central New York (Ann Monroe); Oshei Foundation (Robert Goia); Towers Foundation (Tracy Sawicki)	Bridge funding	Fund MCC initiatives via coalition grants
Christine Blidy (Blue Cross Blue Shield); Anthony Montagna (Independent Health); Carla D'Angelo (YourCare); John Place (Fidelis Care)	VBP transformation	Establish VBP partnerships with MCC providers; share essential data with MCC to facilitate development of VBP strategies

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IPQR Module 3.7 - IT Expectations

Instructions :

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

The finance workstream will require a suite of standard accounting applications as well as the ability to pull in data from providers across the PPS. MCC will use existing hardware and software, where possible, for basic financial reporting. It will be critical to be able to bring in progress indicators from other workstreams/projects to convey to finance; this may be done manually at first (similar to the initial financial health assessment), but ultimately we envision a central, integrated repository MCC can use to monitor PPS financial stability. It may be necessary to establish a "reporting portal" for partner organizations to submit financial performance information easily on an ongoing basis. The financial performance of MCC will also be reliant upon IT innovations that support population health and care coordination performance and drive financial results for the MCC PPS.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

Progress reporting will be aligned with a phased approach to implementing the overall financial sustainability strategy. Success will be measured initially by finalizing appointments, staffing the Finance Committee, completing a financial health current state assessment of providers, adopting distressed provider plans, establishing a financially fragile watch list, and developing an MCO Strategy for VBP Transition as well as VBP Transition Plan. These efforts will culminate into a financial sustainability strategy, which will be used to report quarterly project- and unit-level progress.

The progress of MCC's financial sustainability efforts will be measured by:

Finalized finance structure, including reporting structure approved by the Board of Managers

Finalized Compliance Plan consistent with NYS Social Services Law 363-d approved by the Finance Committee and Board of Managers

Development of a VBP Sub-Committee charter to be approved by the Finance Committee and Board of Managers

Development of a set of principles to guide development of multi-year strategic plan to transition to a system that has 90% of Medicaid payment under a VBP system to be approved by the Finance Committee and Board of Managers

Development of a systematic approach to designing and conducting annual provider financial health evaluation policies and procedures approved by the Finance Committee and Board of Managers

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A network financial health current state assessment

Provider willingness and readiness assessments within the network to engage in various levels of VBP contracting

Development of communication and education plans explaining NYS DOH's VBP agenda and goals

Quarterly project- and unit- level reports to mark progress towards financial sustainability will include but are not limited to:

Finance Committee charter, meeting schedule, and minutes

Finance structure/organizational chart and reporting flowchart

Number of financial policies and procedures developed

Number and type of changes and updates to charters, schedules, organizational or reporting structure, policies, and procedures

Number/percent of providers in network that are financially fragile

Progress towards the implementation of a finalized compliance plan for NYS Social Services Law 363-d

Progress towards implementation of a finalized MCO strategy for VBP transition and the VBP transition plan

Percent of care costs going through VBPs (Level 1 and Level 2)

Status of the PPS's financially fragile providers (as defined by specific financial indicators including but not limited to days cash on hand, debt ratio, operating margin, and current ratio); how their financial status affects performance; identification of additional financial fragile partners; actions taken to improve these providers' financial status

All progress reports relating to the Finance workstream will be forwarded to the Finance Committee and the MCC Board of Managers.

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

IPQR Module 3.9 - IA Monitoring

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Instructions :

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Section 04 – Cultural Competency & Health Literacy

IPQR Module 4.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize cultural competency / health literacy strategy.	Completed	This milestone must be completed by 12/31/2015. Cultural competency / health literacy strategy signed off by PPS Board. The strategy should: -- Identify priority groups experiencing health disparities (based on your CNA and other analyses); -- Identify key factors to improve access to quality primary, behavioral health, and preventive health care -- Define plans for two-way communication with the population and community groups through specific community forums -- Identify assessments and tools to assist patients with self-management of conditions (considering cultural, linguistic and literacy factors); and -- Identify community-based interventions to reduce health disparities and improve outcomes.	05/30/2015	12/31/2015	05/30/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task 1. Using the Community Needs Assessment (CNA) as a foundation, MCC will work to uncover health disparities among different cultural, socioeconomic, and linguistic groups by extracting profiles of Medicaid enrollees attributed to MCC by race, ethnicity, primary language, and rural/urban status.	Completed	1. Using the Community Needs Assessment (CNA) as a foundation, MCC will work to uncover health disparities among different cultural, socioeconomic, and linguistic groups by extracting profiles of Medicaid enrollees attributed to MCC by race, ethnicity, primary language, and rural/urban status.	05/30/2015	09/30/2015	05/30/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Based on research findings, determine what factors are causing poor health outcomes among	Completed	2. Based on research findings, determine what factors are causing poor health outcomes among identified population	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
identified population groups (e.g., lack of a regular source of primary care, high emergency department (ED) utilization rates, disease complexity factors). Identify potential reasons for under-utilization of primary care and other services by these populations and define priority communities.		groups (e.g., lack of a regular source of primary care, high emergency department (ED) utilization rates, disease complexity factors). Identify potential reasons for under-utilization of primary care and other services by these populations and define priority communities.							
Task 3. Develop and issue a request for proposals (RFP) from qualified agencies to spearhead MCC's cultural competency and health literacy program. Selected contractor will be responsible for development, implementation, and operation of a comprehensive cultural competency and health literacy program.	Completed	3. Develop and issue a request for proposals (RFP) from qualified agencies to spearhead MCC's cultural competency and health literacy program. Selected contractor will be responsible for development, implementation, and operation of a comprehensive cultural competency and health literacy program.	06/01/2015	10/31/2015	06/01/2015	10/31/2015	12/31/2015	DY1 Q3	
Task 4. Evaluate RFP responses and select qualified entity to operate cultural competency and health literacy program on behalf of MCC.	Completed	4. Evaluate RFP responses and select qualified entity to operate cultural competency and health literacy program on behalf of MCC.	09/30/2015	11/30/2015	09/30/2015	11/30/2015	12/31/2015	DY1 Q3	
Task 5. Selected contractor will survey and canvass community-based organizations (CBOs), both those with a long tradition of serving at-risk communities and those that are emerging (particularly in new/immigrant neighborhoods). Objective is to gain further knowledge of the reasons for under-utilization of healthcare services, obtain suggestions for improving access to primary and behavioral health services, and shed light on the service roles and capabilities of these CBOs.	Completed	5. Selected contractor will survey and canvass community-based organizations (CBOs), both those with a long tradition of serving at-risk communities and those that are emerging (particularly in new/immigrant neighborhoods). Objective is to gain further knowledge of the reasons for under-utilization of healthcare services, obtain suggestions for improving access to primary and behavioral health services, and shed light on the service roles and capabilities of these CBOs.	10/15/2015	12/31/2015	10/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Contractor will interview healthcare practitioners and support staff located within or near targeted communities to assess the cultural competency of providers (e.g., language and composition of provider staff) and uncover	Completed	6. Contractor will interview healthcare practitioners and support staff located within or near targeted communities to assess the cultural competency of providers (e.g., language and composition of provider staff) and uncover barriers to care (e.g., location of offices, operating hours, lack of transportation).	10/15/2015	12/31/2015	10/15/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
barriers to care (e.g., location of offices, operating hours, lack of transportation).									
Task 7. MCC will issue a survey instrument requesting practitioners and provider representatives to complete a self-assessment that will help gauge health literacy and cultural competency training needs.	Completed	7. MCC will issue a survey instrument requesting practitioners and provider representatives to complete a self-assessment that will help gauge health literacy and cultural competency training needs.	10/12/2015	12/31/2015	10/12/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Contractor will conduct a gap assessment to: (a) compare health disparities of specific targeted populations with linguistic and other cultural competency determinants among community providers; (b) evaluate accessibility of services at those locations where target populations receive care; (c) identify roles and extent to which CBOs are involved in serving target populations ; and (d) develop findings to spur future action.	Completed	8. Contractor will conduct a gap assessment to: (a) compare health disparities of specific targeted populations with linguistic and other cultural competency determinants among community providers; (b) evaluate accessibility of services at those locations where target populations receive care; (c) identify roles and extent to which CBOs are involved in serving target populations ; and (d) develop findings to spur future action.	10/12/2015	12/31/2015	10/12/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 9. Working in concert with MCC, cultural competency and health literacy contractor will reach out to Medicaid Managed Care Organizations, local literacy groups , MCC project leaders, behavioral health professionals, agencies serving the developmentally disabled, and others (e.g., P2 Collaborative of WNY) to obtain recommendations on: (a) language-appropriate patient engagement materials; (b) techniques for engaging patients with low literacy rates; (c) use of teach-back methods in patient-centered medical homes and other settings; (d) assessments and tools to assist patients with self-management of conditions; and (d) other tools for promoting health literacy.	Completed	9. Working in concert with MCC, cultural competency and health literacy contractor will reach out to Medicaid Managed Care Organizations, local literacy groups , MCC project leaders, behavioral health professionals, agencies serving the developmentally disabled, and others (e.g., P2 Collaborative of WNY) to obtain recommendations on: (a) language-appropriate patient engagement materials; (b) techniques for engaging patients with low literacy rates; (c) use of teach-back methods in patient-centered medical homes and other settings; (d) assessments and tools to assist patients with self-management of conditions; and (d) other tools for promoting health literacy.	10/19/2015	12/31/2015	10/19/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 10. Based on canvass, interviews, and assessments, develop literature and material to	Completed	10. Based on canvass, interviews, and assessments, develop literature and material to improve health literacy of targeted populations that cover topics such as when to use the ED, the	09/14/2015	12/31/2015	09/14/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
improve health literacy of targeted populations that cover topics such as when to use the ED, the importance of primary care, overcoming mental health stigma, navigating the health system, and questions to ask your provider.		importance of primary care, overcoming mental health stigma, navigating the health system, and questions to ask your provider.							
Task 11. Engage the "Voice of the Consumer" Sub-Committee and CBO Task Force to assist in the health literacy improvement effort. Members of these groups will review patient education materials, make recommendations to improve patient communications, and provide plain language suggestions to enhance patient understanding of written materials (prescriptions, discharge plans, educational materials, treatment orders, etc.).	Completed	11. Engage the "Voice of the Consumer" Sub-Committee and CBO Task Force to assist in the health literacy improvement effort. Members of these groups will review patient education materials, make recommendations to improve patient communications, and provide plain language suggestions to enhance patient understanding of written materials (prescriptions, discharge plans, educational materials, treatment orders, etc.).	09/14/2015	12/31/2015	09/14/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 12. Develop and finalize plan for distributing health literacy materials via the MCC website and at primary care practices, mental health clinics, drug and alcohol treatment centers, EDs, hospitals, and agencies serving the developmentally disabled, etc.	Completed	12. Develop and finalize plan for distributing health literacy materials via the MCC website and at primary care practices, mental health clinics, drug and alcohol treatment centers, EDs, hospitals, and agencies serving the developmentally disabled, etc.	10/30/2015	12/31/2015	10/30/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 13. Utilizing findings from cultural competency gap assessment, evidence-based cultural competency approaches, and health literacy-related recommendations, contractor will prepare draft Cultural Competency and Health Literacy Strategy, including planned training initiatives and community-based interventions to reduce health disparities and improve outcomes.	Completed	13. Utilizing findings from cultural competency gap assessment, evidence-based cultural competency approaches, and health literacy-related recommendations, contractor will prepare draft Cultural Competency and Health Literacy Strategy, including planned training initiatives and community-based interventions to reduce health disparities and improve outcomes.	11/02/2015	12/31/2015	11/02/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 14. Submit proposed Cultural Competency and Health Literacy Strategy to Clinical/Quality Committee, CBO Task Force, and "Voice of the Consumer" Sub-Committee for their review.	Completed	14. Submit proposed Cultural Competency and Health Literacy Strategy to Clinical/Quality Committee, CBO Task Force, and "Voice of the Consumer" Sub-Committee for their review. Amend plan to reflect recommendations.	11/15/2015	12/31/2015	11/15/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Amend plan to reflect recommendations.									
Task 15. Submit Cultural Competency and Health Literacy Strategy, including training plan, to Board of Managers for approval and post approved plan on MCC website.	On Hold	15. Submit Cultural Competency and Health Literacy Strategy, including training plan, to Board of Managers for approval and post approved plan on MCC website.	11/30/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 16. Establish system for issuing quarterly reports to provide updates on Cultural Competency and Health Literacy Strategy.	Completed	16. Establish system for issuing quarterly reports to provide updates on Cultural Competency and Health Literacy Strategy.	11/15/2015	12/31/2015	11/15/2015	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	07/09/2015	06/30/2016	07/09/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task 1. Issue an RFP from CBOs to serve as trainers for MCC's cultural and health literacy program. A minimum of 12 CBOs representative of the three sub-regions of the PPS (North: Niagara and Orleans Counties; Central: Erie, Genesee, and Wyoming Counties; and South: Allegany, Cattaraugus, and Chautauqua Counties) will be selected.	In Progress	1. Issue an RFP from CBOs to serve as trainers for MCC's cultural and health literacy program. A minimum of 12 CBOs representative of the three sub-regions of the PPS (North: Niagara and Orleans Counties; Central: Erie, Genesee, and Wyoming Counties; and South: Allegany, Cattaraugus, and Chautauqua Counties) will be selected.	10/15/2015	03/31/2016	10/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2. Select CBOs responding to survey based on their capabilities and the extent to which they serve under-served population groups and communities that were identified in previous research (milestone #1).	In Progress	2. Select CBOs responding to survey based on their capabilities and the extent to which they serve under-served population groups and communities that were identified in previous research (milestone #1).	11/15/2015	03/31/2016	11/15/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Working with IT team, contractor will develop content for web-based cultural competency and	In Progress	Working with IT team, contractor will develop content for web-based cultural competency and health literacy learning platform.	11/15/2015	06/30/2016	11/15/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
health literacy learning platform.									
Task 4. Contractor will develop a comprehensive plan for providing in-person and web-based cultural competency and health literacy training to representatives of CBOs.	In Progress	Contractor will develop a comprehensive plan for providing in-person and web-based cultural competency and health literacy training to representatives of CBOs.	11/15/2015	06/30/2016	11/15/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Commence training of CBO representatives who will serve as trainers for the cultural competency and health literacy initiative.	Not Started	Commence training of CBO representatives who will serve as trainers for the cultural competency and health literacy initiative.	01/04/2016	06/30/2016	01/04/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Develop and wage an ongoing communication effort to encourage MCC partners to actively engage in training and other programming to improve the cultural and health literacy competency of partners' providers and staff. Work will be led by MCC communication staff with input from health literacy/cultural competency contractor, "Voice of the Consumer" Sub-Committee, and CBO Task Force.	In Progress	Develop and wage an ongoing communication effort to encourage MCC partners to actively engage in training and other programming to improve the cultural and health literacy competency of partners' providers and staff. Work will be led by MCC communication staff with input from health literacy/cultural competency contractor, "Voice of the Consumer" Sub-Committee, and CBO Task Force.	11/15/2015	06/30/2016	11/15/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 7. Recruit cultural competency champions from MCC-affiliated providers, agencies, and CBOs.	Completed	Recruit cultural competency champions from MCC-affiliated providers, agencies, and CBOs.	07/09/2015	06/30/2016	07/09/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Using results of gap assessment and other findings, develop priority target list of providers, agencies, and CBO sites for cultural competency and health literacy training.	In Progress	Using results of gap assessment and other findings, develop priority target list of providers, agencies, and CBO sites for cultural competency and health literacy training.	12/15/2015	06/30/2016	12/15/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 9. Working in concert with cultural competency champions, schedule onsite cultural competency and health literacy training that will be provided by trained CBO representatives as well as by contractor.	Not Started	Working in concert with cultural competency champions, schedule onsite cultural competency and health literacy training that will be provided by trained CBO representatives as well as by contractor.	01/04/2016	06/30/2016	01/04/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 10. Begin onsite training at MCC partner sites, including primary care practices, behavioral	Not Started	Begin onsite training at MCC partner sites, including primary care practices, behavioral health agencies, addiction treatment centers, CBO service sites, etc. directed to	01/25/2016	06/30/2016	01/25/2016	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
health agencies, addiction treatment centers, CBO service sites, etc. directed to practitioners and staff and focused on the core competencies of delivering culturally competent, health-literate care.		practitioners and staff and focused on the core competencies of delivering culturally competent, health-literate care.							
Task 11. Populate cultural competency and health literacy learning platform with lessons learned and continue to build educational resources on the website.	Not Started	Populate cultural competency and health literacy learning platform with lessons learned and continue to build educational resources on the website.	02/15/2016	06/30/2016	02/15/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 12. Perform an evaluation of cultural competency and health literacy training initiative to pinpoint any gaps and needed improvements to strengthen training before proceeding to the next training phase. Use pre- and post-training assessments to determine effectiveness.	Not Started	Perform an evaluation of cultural competency and health literacy training initiative to pinpoint any gaps and needed improvements to strengthen training before proceeding to the next training phase. Use pre- and post-training assessments to determine effectiveness.	03/15/2016	06/30/2016	03/15/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 13. Review progress and issue first quarterly report to MCC Board of Managers, "Voice of the Consumer" Sub-Committee, and CBO Task Force on number of partners receiving training, participant-level data, description of training provided, training outcomes, health literacy materials that have been developed and tested by consumer input, and other cultural competency and health literacy activities.	Not Started	Review progress and issue first quarterly report to MCC Board of Managers, "Voice of the Consumer" Sub-Committee, and CBO Task Force on number of partners receiving training, participant-level data, description of training provided, training outcomes, health literacy materials that have been developed and tested by consumer input, and other cultural competency and health literacy activities.	03/31/2016	06/30/2016	03/31/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	ethelen	Other	48_MDL0403_1_3_20160316142533_CC_01_Milestone_remediation_narrative.pdf	Millennium's narrative response to IA remediation comments	03/16/2016 02:25 PM
	ethelen	Other	48_MDL0403_1_3_20160316142425_CC_01_CCHL_Strategy_REVISED.pdf	REVISED Millennium's cultural competency/health literacy strategy	03/16/2016 02:24 PM
	ethelen	Other	48_MDL0403_1_3_20160201121640_CC_01_deliverables.pdf	COVER PAGE: Describes documentation provided as evidence of completion of this milestone	02/01/2016 12:16 PM
	ethelen	Meeting Materials	48_MDL0403_1_3_20160201121545_CC_01_03_Community_Groups_Meetings_DY1Q3.xlsx	Spreadsheet listing meetings and other types of outreach with community groups	02/01/2016 12:15 PM
	ethelen	Other	48_MDL0403_1_3_20160201121051_CC_01_01_CCHL_Strategy.pdf	Millennium's cultural competency/health literacy strategy was reviewed, revised, and approved by various committees and entities in December 2015.	02/01/2016 12:10 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	One task has been completed and others are on target/in progress.

Milestone Review Status

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

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IPQR Module 4.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

PPS provider receives revenue from MCC without Cultural Competency/Health Literacy training. Provide classes with continuing education credits and celebrate all providers who complete training in PPS publications and on social media.

CBOs are not compensated or recognized for their participation in training. Include training compensation and recognition. Create an accreditation (e.g., CBOs of Health Excellence).

Training is considered unnecessary or a waste of time. The training design is to teach and entertain in order to create memorable moments. We will use the Program to Enhance Relational and Communication Skills (PERCS) model of realistic enactments with professional actors, collaborative learning, reflection, and feedback.

Stability of CBOs. Many CBOs are small, with a small staff who are already multi-tasking, and insecure funding. This project requires stable, experienced CBOs so clients have confidence in them being there when they need them. We also need to know that the trainers we invest in are going to able to attend "train the trainer" sessions and consistently serve as lead trainers. Include an organizational profile which includes financials and staffing as part of the RFP process for selecting CBOs who will serve as lead trainers. Also consider the number of clients they serve and whether or not they have multiple sites. Identifying these organizations as primary training sites would increase our opportunity to reach the underserved/uninsured population we are seeking.

An individual's literacy level is a highly personal and sensitive area that requires building trust with a nonjudgmental approach. In addition to the CBOs, we also need to provide in-community health literacy collaborations which include public libraries and faith-based sites to make health literacy a community initiative. The objective will be to reach community members in the diverse environments where they are already comfortable, to maximize consumer engagement.

Overlapping PPSs in WNY. Work with Community Partners of WNY (led by Catholic Medical Partners) and Finger Lakes PPS to coordinate efforts. MCC has met with the other PPSs and with the Population Health Improvement Program grantee in WNY (P2 Collaborative of WNY) to identify potential areas of collaboration including conducting focus groups; designing training programs; and collecting quality metrics related to race, ethnicity, and language.

Lack of patient engagement. Changes are made "in a vacuum" and do not meet actual patient/caregiver needs. Community participants play vital roles in the cultural competency and health literacy training development and its successful implementation. Their participation and feedback in assessments, through focus groups, on social media, and in face-to-face meetings will instruct us on what will work, what does not, and how we should change things in order to make this healthcare transformation meet their needs.

IPQR Module 4.4 - 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.)

There are several interdependencies between the cultural competency and health literacy workstream and other workstreams and project initiatives:

Cultural competency and health literacy training will be a key element of clinical integration activities. The aim is to give providers the training they need to be sensitive and responsive to the cultural needs of their patients, a key element for promoting ongoing patient engagement with the healthcare system.

The cultural competency and health literacy program will buttress the project 2.d.i. (Patient Activation). All patient activation coaches will be required to complete cultural competency and health literacy training as a means for improving their effectiveness in motivating patients and making sure they understand medication and plan of care instructions.

The effectiveness of the cultural competency and health literacy program will be dependent upon a supportive governing body that elevates the importance of this work.

The cultural competency and health literacy effort will be dependent upon the strength of CBOs. At least 12 CBOs will serve as cultural competency and health literacy trainers, and the CBO community will be tapped to promote participation in this essential training.

The effectiveness of the PPS's communication strategies will be dependent upon the use of health literate educational materials and other communications that can be readily understood by diverse cultural and ethnic communities across WNY.

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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
MCC Director of Community-Based Initiatives	Catherine Lewis	Solicit and engage CBOs; secure master agreements; coordinate "Voice of the Consumer" Sub-Committee and CBO Task Force
Workforce vendor selected via RFP process	Rural AHEC (Valerie Putney, David Prete)	Implement PPS workforce development and training strategies, incorporating cultural competency and health literacy topics
MCC Operations Director	Juan Santiago	Manage RFP/procurement process
Cultural competency champions	CBOs, PPS partners selected via RFP process	Attend "train the trainer" classes; coordinate and deliver cultural competency/health literacy activities to community members at their respective sites
Minority business relations	Janique Curry	Facilitate inclusion of Minority- and Women-Owned Business Enterprises (MBE/WBEs); support organizations seeking MBE/WBE certification

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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		
Providers	Patient care	Ensure office practices are sensitive to cultural diversity and health concerns of their population; deliver culturally sensitive care
MCC Continuing Education Manager	Training oversight	Ensure all training is conducted with cultural sensitivity; develop training necessary for raising awareness on cultural diversity and health literacy; consider a dissemination plan for education developed
Staff	Consumer and patient administrative support	Ensure staff conducts business with astuteness for cultural diversity and various health literacy levels; deliver culturally sensitive care
"Voice of the Consumer" Sub-Committee	Community participation	Encourage awareness of cultural norms; support diversity; provide feedback on training and other materials
CBO Task Force	Services	Encourage awareness of cultural norms; support diversity; provide feedback on training and other materials
CBO staff trained to serve as trainers	Services	Provide culturally aware and health literacy-appropriate services; coordinate with MCC physicians to ensure care addresses barriers to care
External Stakeholders		
Patients, families, caregivers	Care seekers	Remove barriers to effective care due to cultural sensitivities; strive towards personal success goals
211 resource directory	Consumer resource information	Provide links to and information about culturally aware and health literacy-appropriate services
Literacy Volunteers of Buffalo	Educational resource	Include topic of health and cultural diversity in literacy education
Centers for Disease Control and Prevention	Resource for patients and caregivers	Provide free educational materials for varied cultural ethnicities and languages
Safety net primary care practices (e.g., Jericho Road)	PCP/FQHC	Provide medical care in a transcultural, diverse, and culturally sensitive medical home especially for refugees and low-income community members
Various organizations: International Institute; Journey's End; Jewish Family Services; Hispanics United of Buffalo (HUB); Native American	Support, outreach, advocacy	Provide support and outreach services tailored to specific populations and groups; ensure services are offered in culturally sensitive and linguistically appropriate formats; promote community

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Community Services; area Indian reservations; Olmsted Center for the Blind; Deaf Access Services; St. Mary's School for the Deaf; Gay/Lesbian Youth Services (GLYS); Pride Center of WNY; Autism Services Inc. of WNY; etc.		awareness and understanding of specific populations/groups
UB Educational Opportunity Center	Literacy and workforce development	Literacy for adults; culturally sensitive workforce development services
Local school districts, BOCES	Education resources	Literacy for adults and children
Community-based organizations (e.g., Catholic Charities)	Social determinant of health support services, i.e., counseling, housing, etc.	Offer supportive guidance services with cultural diversity and literacy sensitivity
Community health workers	Care coordination	Provide care coordination/navigation services in culturally and linguistically appropriate formats/settings
Behavioral health providers (e.g., Lakeshore Behavioral Health)	Behavioral health services	Work with refugee population
Retired Peace Corps Volunteer Group	Speakers for community forums	Assist with cultural awareness discussions, forums, and roundtables
Local government units	Education resources	Offer publicly available culturally sensitive educational materials and services (if applicable)

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.

A shared IT infrastructure will be used to store and disseminate standardized health education and sample conversation scripts that will be used by providers throughout the PPS. This information will be pre-authorized with respect to meeting cultural competency and health literacy standards. A shared IT structure will also be used to track and monitor partner engagement in cultural competency and health literacy training.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

Progress reporting will be aligned with the phased approach to implementing the overall cultural competency strategy. Establishment of project- and unit-level reporting frequency will be based on the internal and external reporting requirements to ensure the success of the PPS-wide cultural competency strategy which will be consistent with cultural and linguistic needs of the population.

The progress of MCC's cultural competency and health literacy efforts will be measured by:
Finalizing the makeup of various committees/groups (CBO Task Force, etc.)
Designing and administering stakeholder and health literacy assessments
Aggregating and analyzing responses to identify gaps and areas of focus
Communicating the results
Developing a comprehensive training strategy to address drivers of health disparities to be approved by the Board of Managers
Progress towards these overall goals will be reported quarterly based on several indicators, such as:
Percentage of assessments completed
Health disparities relating to access to care among uninsured and low/non-utilizing Medicaid patients
The percentage of uninsured and low/non-utilizing Medicaid patients who completed a patient activation screen and are connected to care

The progress of the MCC cultural competency training plans will be analyzed and reports will be developed to assess the following:
Number of training programs delivered each quarter
Geographical locations of trainings
Number of CBOs serving as cultural competency/health literacy trainers
Number of CBO staff trained to serve as trainers
Percentage of total PPS partners who participated in cultural competency/health literacy training

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Percentage of partner staff who completed training
Training outcomes (use pre- and post-training assessments to determine effectiveness)
Training satisfaction rate

Monthly and quarterly reports will track development of materials/programs/publications and the status of efforts to test these materials in pilots or focus groups.

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

IPQR Module 4.9 - IA Monitoring

Instructions :

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Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1. Establish an IT governance structure including a charter, goals and objectives, reporting structure, budget, and reporting responsibilities. IT governance will engage representatives from all entities in the MCC corporate structure to participate in the IT governance process.	Completed	1. Establish an IT governance structure including a charter, goals and objectives, reporting structure, budget, and reporting responsibilities. IT governance will engage representatives from all entities in the MCC corporate structure to participate in the IT governance process.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Define requirements to provide IT solutions to meet the goals and objectives outlined in MCC IT needs, including but not limited to: an enterprise DSRIP solution blueprint, EHR, care management, direct messaging, patient portal, patient activation, population health, telehealth, HEDIS, grouping (3M), security tools, and back office tools including project management and finance software.	Completed	2. Define requirements to provide IT solutions to meet the goals and objectives outlined in MCC IT needs, including but not limited to: an enterprise DSRIP solution blueprint, EHR, care management, direct messaging, patient portal, patient activation, population health, telehealth, HEDIS, grouping (3M), security tools, and back office tools including project management and finance software.	05/01/2015	12/31/2015	05/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Determine approach to assessing the capabilities of MCC participants and their ability to meet the requirements defined in Step 2. MCC	In Progress	3. Determine approach to assessing the capabilities of MCC participants and their ability to meet the requirements defined in Step 2. MCC participants to include all providers of services (medical, behavioral, post-acute, long-term care, and	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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participants to include all providers of services (medical, behavioral, post-acute, long-term care, and community-based service providers as well as payers and social service organizations). Approach will leverage existing data sources and direct interviews and surveys as appropriate.		community-based service providers as well as payers and social service organizations). Approach will leverage existing data sources and direct interviews and surveys as appropriate.							
Task 4. Assess capabilities from HEALTHeLINK (Qualified Entity) against defined requirements. Review HEALTHeLINK proposal to support DSRIP organizations.	In Progress	4. Assess capabilities from HEALTHeLINK (Qualified Entity) against defined requirements. Review HEALTHeLINK proposal to support DSRIP organizations.	05/01/2015	03/31/2016	05/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. Roll out initial communication and education to all PPS members via electronic means and workshops.	In Progress	5. Roll out initial communication and education to all PPS members via electronic means and workshops.	05/01/2015	03/31/2016	05/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6. Conduct current state assessment utilizing the approach identified in task 3. Gathered data should focus on vendors, systems, and applications; interoperability capabilities; capabilities of staff; and industry standards for data exchange.	In Progress	6. Conduct current state assessment utilizing the approach identified in task 3. Gathered data should focus on vendors, systems, and applications; interoperability capabilities; capabilities of staff; and industry standards for data exchange.	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Develop high-level gap analysis against enterprise DSRIP solution blueprint. Prioritize defined gaps against the potential impact of the gap and required timeline for delivery.	In Progress	7. Develop high-level gap analysis against enterprise DSRIP solution blueprint. Prioritize defined gaps against the potential impact of the gap and required timeline for delivery.	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8. Develop strategy and approaches to closing or remediating identified gaps. Potential strategies include leveraging existing capabilities, selecting/procuring new solution sets, and/or providing services and capabilities to MCC participants directly. In addition, document MCC's intentions to leverage technology to support its business and strategic vision through development of the IT Target Operating Model (TOM). The TOM plan will include business	In Progress	8. Develop strategy and approaches to closing or remediating identified gaps. Potential strategies include leveraging existing capabilities, selecting/procuring new solution sets, and/or providing services and capabilities to MCC participants directly. In addition, document MCC's intentions to leverage technology to support its business and strategic vision through development of the IT Target Operating Model (TOM). The TOM plan will include business operations model and IT systems model deliverables which include working, outcomes, access, care coordination, and prevention views.	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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operations model and IT systems model deliverables which include working, outcomes, access, care coordination, and prevention views.									
Task 9. Develop implementation plan based upon the identified gaps. Include capabilities, intended organizations, technical approach, capital, and resources required for successful implementation.	In Progress	9. Develop implementation plan based upon the identified gaps. Include capabilities, intended organizations, technical approach, capital, and resources required for successful implementation.	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 10. Obtain Board of Managers approval for IT strategy and IT implementation plan.	In Progress	10. Obtain Board of Managers approval for IT strategy and IT implementation plan.	12/01/2015	03/31/2016	12/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1. Develop MCC IT and Organizational Change Management Strategy including oversight and governance processes and interaction/monitoring by appropriate entities. Ensure change strategy takes into account degree of resistance, target population, timeframes, expertise, workforce, and dependencies.	In Progress	1. Develop MCC IT and Organizational Change Management Strategy including oversight and governance processes and interaction/monitoring by appropriate entities. Ensure change strategy takes into account degree of resistance, target population, timeframes, expertise, workforce, and dependencies.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	
Task 2. Conduct IT and organizational change readiness assessment, internally and externally throughout the PPS network. Determine scope of change, impacted groups, and numbers of employees (both MCC internal and partner network), organization's change capacity, acceptance of change in their culture, leadership	In Progress	2. Conduct IT and organizational change readiness assessment, internally and externally throughout the PPS network. Determine scope of change, impacted groups, and numbers of employees (both MCC internal and partner network), organization's change capacity, acceptance of change in their culture, leadership style (internal and with partners), and power distribution.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
style (internal and with partners), and power distribution.									
Task 3. Identify change agents throughout the network.	In Progress	3. Identify change agents throughout the network.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Define and inventory current end user roles and responsibilities. Align current roles and responsibilities with proposed roles and responsibilities.	Not Started	4. Define and inventory current end user roles and responsibilities. Align current roles and responsibilities with proposed roles and responsibilities.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 5. Identify areas where roles will be created or eliminated; assess impact on job descriptions, performance evaluations, etc.	Not Started	5. Identify areas where roles will be created or eliminated; assess impact on job descriptions, performance evaluations, etc.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 6. Build training plans based on role-based training.	Not Started	6. Build training plans based on role-based training.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 7. Communicate change management policies to all stakeholders for management of high-impact changes that affect the entire PPS. Communication plan will be centered around "stop/start/continue" methodology.	Not Started	7. Communicate change management policies to all stakeholders for management of high-impact changes that affect the entire PPS. Communication plan will be centered around "stop/start/continue" methodology.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 8. Activate change agents to conduct workshops throughout partner networks. Change agents will identify tips, tricks, and other info/material they need to help their co-workers adapt to change.	Not Started	8. Activate change agents to conduct workshops throughout partner networks. Change agents will identify tips, tricks, and other info/material they need to help their co-workers adapt to change.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 9. Develop and implement IT-specific training within the PPS's workforce training programs.	Not Started	9. Develop and implement IT-specific training within the PPS's workforce training programs.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 10. Maintain training register/learning management system to monitor progress, training participation rates, and outcomes. Use formal and informal surveys to assess training effectiveness.	Not Started	10. Maintain training register/learning management system to monitor progress, training participation rates, and outcomes. Use formal and informal surveys to assess training effectiveness.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task	Not Started	11. Assign responsibility for driving the IT and Organizational	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	

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11. Assign responsibility for driving the IT and Organizational Change Management Strategy to members of the IT Data Committee and other key stakeholders as appointed by the Board of Managers.		Change Management Strategy to members of the IT Data Committee and other key stakeholders as appointed by the Board of Managers.							
Task 12. Establish change management procedures including the following tasks: review, approve/reject, communicate, and monitor including tracking and reporting.	Not Started	12. Establish change management procedures including the following tasks: review, approve/reject, communicate, and monitor including tracking and reporting.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 13. Develop or procure a tool or technology to assist in management of the change management system.	Not Started	13. Develop or procure a tool or technology to assist in management of the change management system.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 14. Coordinate and communicate all activities to stakeholders including PPS members to leverage the change management system.	Not Started	14. Coordinate and communicate all activities to stakeholders including PPS members to leverage the change management system.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 15. Build an appropriate change management culture throughout the MCC community.	Not Started	15. Build an appropriate change management culture throughout the MCC community.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 16. Develop the impact analysis processes for change requests. These processes should address contingencies, allow stakeholders to communicate concerns, identify and establish a specific maintenance window, and include an adequate fallback plan.	Not Started	16. Develop the impact analysis processes for change requests. These processes should address contingencies, allow stakeholders to communicate concerns, identify and establish a specific maintenance window, and include an adequate fallback plan.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 17. Define processes and workflows including but not limited to documentation of information related to high-level testing, communication and resource plans, required meetings, timely decisions, change management work processes, and post-change analysis for process improvements.	Not Started	17. Define processes and workflows including but not limited to documentation of information related to high-level testing, communication and resource plans, required meetings, timely decisions, change management work processes, and post-change analysis for process improvements.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 18. The Board of Managers will review/approve	Not Started	18. The Board of Managers will review/approve the IT and Organizational Change Management Strategy.	11/01/2016	03/31/2017	11/01/2016	03/31/2017	03/31/2017	DY2 Q4	

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the IT and Organizational Change Management Strategy.									
Task 19. Conduct quarterly audits of the change control process, ensuring its effectiveness and modifying the IT and Organizational Change Management Strategy as needed.	Not Started	19. Conduct quarterly audits of the change control process, ensuring its effectiveness and modifying the IT and Organizational Change Management Strategy as needed.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 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 with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task 1. Perform current state assessment as described in milestone #1, including hardware and software readiness, EMR capabilities, and interoperability with HEALTHeLINK/RHIO.	Completed	1. Perform current state assessment as described in milestone #1, including hardware and software readiness, EMR capabilities, and interoperability with HEALTHeLINK/RHIO.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Determine the need for data sharing agreements between MCC and all participating PPS providers. Review the applicable law and assess agreements for data sharing currently in use by Qualified Entity (HEALTHeLINK) and MCC providers.	Completed	2. Determine the need for data sharing agreements between MCC and all participating PPS providers. Review the applicable law and assess agreements for data sharing currently in use by Qualified Entity (HEALTHeLINK) and MCC providers.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Establish an MCC data governance framework, which takes into account the	Completed	3. Establish an MCC data governance framework, which takes into account the requirements of the PPS members, their data integration capabilities, and DSRIP project data	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
requirements of the PPS members, their data integration capabilities, and DSRIP project data sharing needs.		sharing needs.							
Task 4. Create policies and procedures for data sharing, including data sharing requirements between PPS members and external entities.	Completed	4. Create policies and procedures for data sharing, including data sharing requirements between PPS members and external entities.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Establish data formatting, nomenclature, and data schema policies for all interfaces including sFTP, PGP encryption, automated interfaces, APIs, and direct queries.	In Progress	5. Establish data formatting, nomenclature, and data schema policies for all interfaces including sFTP, PGP encryption, automated interfaces, APIs, and direct queries.	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6. Based on legal analysis, the DEAAs will incorporate PHI, BAAs, and other elements and will be finalized and executed within the PPS network.	Completed	6. Based on legal analysis, the DEAAs will incorporate PHI, BAAs, and other elements and will be finalized and executed within the PPS network.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 7. Complete the execution of data sharing agreements for key partners within the PPS network.	Completed	7. Complete the execution of data sharing agreements for key partners within the PPS network.	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 8. Verify two-way data flow, where approved and appropriate, to all systems identified. Data flows need to be secure, logged, and monitored.	In Progress	8. Verify two-way data flow, where approved and appropriate, to all systems identified. Data flows need to be secure, logged, and monitored.	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 9. Measure continued improvement against baseline (current state assessment). Begin providing quarterly reports to the Board of Managers detailing the status of the signing and execution of the DEAAs.	In Progress	9. Measure continued improvement against baseline (current state assessment). Begin providing quarterly reports to the Board of Managers detailing the status of the signing and execution of the DEAAs.	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4	
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.	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4	NO
Task 1. Develop high-level strategy engaging PPS members and any community RHIO or data	In Progress	1. Develop high-level strategy engaging PPS members and any community RHIO or data exchange (Qualified Entities) entity which are identified as critical to the success of this	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
exchange (Qualified Entities) entity which are identified as critical to the success of this initiative. IT TOM will be utilized to identify requirements and IT systems required to assist in the enablement of patient engagement and RHIO/data exchange.		initiative. IT TOM will be utilized to identify requirements and IT systems required to assist in the enablement of patient engagement and RHIO/data exchange.							
Task 2. Identify gaps for engagement with PPS members and Qualified Entities, including analysis and determination of outreach strategies, patient portals, patient communications, and call centers.	In Progress	2. Identify gaps for engagement with PPS members and Qualified Entities, including analysis and determination of outreach strategies, patient portals, patient communications, and call centers.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 3. Identify remediation for gaps in engagement with PPS members and Qualified Entities.	In Progress	3. Identify remediation for gaps in engagement with PPS members and Qualified Entities.	11/01/2015	12/31/2016	11/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 4. Define patient engagement goals and objectives; include metrics and monitoring processes to verify adherence to goals and objectives.	Not Started	4. Define patient engagement goals and objectives; include metrics and monitoring processes to verify adherence to goals and objectives.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 5. From Steps 1-4, develop plan to implement and maintain engagement. This includes workflows, processes, procedures, and tools.	Not Started	5. From Steps 1-4, develop plan to implement and maintain engagement. This includes workflows, processes, procedures, and tools.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 6. As part of the development of the Engagement Strategy and Plan, we will utilize our IT and Organizational Change Management Strategy (as described in milestone #2) to identify the different communication methods and techniques including objectives and proposed tools. - Provider-to-Provider - Provider-to-MCC - Provider-to-Home Care - Patient-to-Provider - External Entity-to-Caregiver	Not Started	6. As part of the development of the Engagement Strategy and Plan, we will utilize our IT and Organizational Change Management Strategy (as described in milestone #2) to identify the different communication methods and techniques including objectives and proposed tools. - Provider-to-Provider - Provider-to-MCC - Provider-to-Home Care - Patient-to-Provider - External Entity-to-Caregiver	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 7. Identify the linguistic requirements of the	Not Started	7. Identify the linguistic requirements of the region. Incorporate any linguistic requirements into the IT portion of	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4	

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region. Incorporate any linguistic requirements into the IT portion of the Engagement Strategy and Plan as needed. Dependent on development of member-accessible system via patient portal or otherwise. This work will be done in conjunction with the implementation of the solution, the Cultural Competency and Health Literacy workstream, and the IT and Organizational Change Management Strategy.		the Engagement Strategy and Plan as needed. Dependent on development of member-accessible system via patient portal or otherwise. This work will be done in conjunction with the implementation of the solution, the Cultural Competency and Health Literacy workstream, and the IT and Organizational Change Management Strategy.							
Task 8. Finalize Engagement Strategy and Plan including milestones, workflows, processes, procedures, objectives, and proposed tools.	Completed	8. Finalize Engagement Strategy and Plan including milestones, workflows, processes, procedures, objectives, and proposed tools.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 9. MCC Governance Committee with Clinical Integration Officer reviews and approves Engagement Strategy and Plan.	Completed	9. MCC Governance Committee with Clinical Integration Officer reviews and approves Engagement Strategy and Plan.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 10. Identify and design tools to address the engagement plan. Identify business/technical requirements including final architecture and downselection of solutions. Determine whether to develop the system internally or leverage a third party. Develop RFP for engagement plan/communication tool.	Completed	10. Identify and design tools to address the engagement plan. Identify business/technical requirements including final architecture and downselection of solutions. Determine whether to develop the system internally or leverage a third party. Develop RFP for engagement plan/communication tool.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 11. Select vendor from the RFP.	In Progress	11. Select vendor from the RFP.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 12. Acquire and customize tools for the Engagement Strategy and Plan.	In Progress	12. Acquire and customize tools for the Engagement Strategy and Plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 13. Develop and implement workflows, processes, and procedures to support the Engagement Strategy and Plan.	In Progress	13. Develop and implement workflows, processes, and procedures to support the Engagement Strategy and Plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 14. Communicate to PPS members and deploy to MCC the Engagement Strategy and Plan including tools.	In Progress	14. Communicate to PPS members and deploy to MCC the Engagement Strategy and Plan including tools.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone #5 Develop a data security and confidentiality plan.	Completed	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	NO
Task 1. Develop a Data Security and Confidentiality Plan.	Completed	1. Develop a Data Security and Confidentiality Plan.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. Develop Security Charter and IT Security Program and Management Processes. Obtain Board of Managers approval of program.	Completed	2. Develop Security Charter and IT Security Program and Management Processes. Obtain Board of Managers approval of program.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 3. Coordinate definition and establishment of IT Security Policies and Protocols including data usage policies, data handling policies, and sanctions and penalties policies. Obtain IT Data Committee approval of program.	Completed	3. Coordinate definition and establishment of IT Security Policies and Protocols including data usage policies, data handling policies, and sanctions and penalties policies. Obtain IT Data Committee approval of program.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 4. Perform risk analysis of Information security risks, regulatory requirements, and design of controls to mitigate risk. The results of this assessment will be integrated into the IT Security Policies and Protocols to mitigate the identified risk.	Completed	4. Perform risk analysis of Information security risks, regulatory requirements, and design of controls to mitigate risk. The results of this assessment will be integrated into the IT Security Policies and Protocols to mitigate the identified risk.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 5. Provide IT Security Policies and Protocols to be integrated by the IT Data Committee for implementation in all infrastructure, applications, and back office and communications tools deployed.	Completed	5. Provide IT Security Policies and Protocols to be integrated by the IT Data Committee for implementation in all infrastructure, applications, and back office and communications tools deployed.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Establish requirements for monitoring data misuse by PPS partners and staff - Establish logging and monitoring requirements and the support system to deliver - Establish IT Security testing tools of IT Security	Completed	6. Establish requirements for monitoring data misuse by PPS partners and staff - Establish logging and monitoring requirements and the support system to deliver - Establish IT Security testing tools of IT Security controls to monitor data misuse	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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controls to monitor data misuse - Design IT Security testing controls - Establish automated monitoring and alerting of PPS member and partner adherence to security policies; include reporting and remediation protocols - Implement IT security testing controls - Monitor interfaces and data exchanges for appropriate use - Establish a risk assessment and analysis program - Annual risk assessment performed - Establish contract with third-party entity(s) to perform vulnerability scanning, penetration testing, security audits, and incident monitoring and response - Utilize the Capability Maturity Model as baseline for all assessments and analysis		- Design IT Security testing controls - Establish automated monitoring and alerting of PPS member and partner adherence to security policies; include reporting and remediation protocols - Implement IT security testing controls - Monitor interfaces and data exchanges for appropriate use - Establish a risk assessment and analysis program - Annual risk assessment performed - Establish contract with third-party entity(s) to perform vulnerability scanning, penetration testing, security audits, and incident monitoring and response - Utilize the Capability Maturity Model as baseline for all assessments and analysis							
Task 7. Establish reporting mechanisms to IT Data Committee and Board of Managers.	Completed	7. Establish reporting mechanisms to IT Data Committee and Board of Managers.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a data security and confidentiality plan.	ethelen	Policies/Procedures	48_MDL0503_1_3_20160314152827_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AT_Family)_03-11-16.docx	REVISED Millennium Systems Security Plan (SSP) workbook for Awareness and Training (AT)	03/14/2016 03:28 PM
	ethelen	Policies/Procedures	48_MDL0503_1_3_20160314152439_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PE_Family)_03-11-16.docx	Millennium Systems Security Plan (SSP) workbook for Physical and Environmental Protection (PE)	03/14/2016 03:24 PM

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	ethelen	Policies/Procedures	48_MDL0503_1_3_20160314152237_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PS_Family)_03-11-16.docx	REVISED Millennium Systems Security Plan (SSP) workbook for Personnel Security (PS)	03/14/2016 03:22 PM
	ethelen	Other	48_MDL0503_1_3_20160202133138_IT_05_deliverables.pdf	COVER PAGE: Describes documentation provided as evidence of completion of this milestone	02/02/2016 01:31 PM
	ethelen	Other	48_MDL0503_1_3_20160202133106_IT_05_04_Security_Incident_Report_and_Log.pdf	Sample security incident report and log	02/02/2016 01:31 PM
	ethelen	Policies/Procedures	48_MDL0503_1_3_20160202131508_IT_05_OHIP_DOS_SSP_Moderate_Plus_Workbook-IR.docx	Millennium Systems Security Plan (SSP) workbook for Incident Response (IR)	02/02/2016 01:15 PM
	ethelen	Policies/Procedures	48_MDL0503_1_3_20160202131435_IT_05_OHIP_DOS_SSP_Moderate_Plus_Workbook-AU.docx	Millennium Systems Security Plan (SSP) workbook for Audit and Accountability (AU)	02/02/2016 01:14 PM
	ethelen	Other	48_MDL0503_1_3_20160202122113_IT_05_03_Security_Personnel_DY1Q3.xlsx	PPS security personnel are listed in the attached spreadsheet	02/02/2016 12:21 PM
	ethelen	Training Documentation	48_MDL0503_1_3_20160202122031_IT_05_02_HIPAA_Training_Schedule_DY1Q3.xlsx	HIPAA training sessions conducted by Millennium are described in the attached spreadsheet	02/02/2016 12:20 PM
	ethelen	Policies/Procedures	48_MDL0503_1_3_20160202121925_IT_05_01_Data_Security_and_Confidentiality_Plan.pdf	Millennium Collaborative Care IT Security Policies, S0002 IT Security Program and S0003 Data Security	02/02/2016 12:19 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	
Develop an IT Change Management Strategy.	
Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	
Develop a specific plan for engaging attributed members in Qualifying Entities	
Develop a data security and confidentiality plan.	As described below, an 11th document for IT milestone #5 is attached to Governance milestone #4. ------ From: DSRIP_IA [mailto:DSRIP_IA@pcgus.com]

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Sent: Wednesday, March 16, 2016 9:49 AM To: 'Turner, Gregory' <gturner@millenniumcc.org>; DSRIP_IA <DSRIP_IA@pcgus.com>; Mane, Jennifer <jmane@pcgus.com>; Sobelson, Naomi <nsobelson@pcgus.com> Cc: Liz Thelen <liz.thelen@ctg.com> Subject: RE: SSP Workbook Question Please attach the document to one of the milestones returned to the PPS for remediation. For Millennium that would be Budget Milestone 1, Governance Milestone 4, or Cultural Competency Milestone 1. Simply attach the document to whichever milestone is most convenient and note this in your narrative for IT Milestone 5. This will allow the IA to download the document through MAPP so it may be reviewed.

Milestone Review Status

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

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IPQR Module 5.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Gap analysis for EHR and data exchange connectivity is not completed in a timely manner. If the gap analysis is delayed, remaining IT implementation steps will be delayed. PMO will clearly define goals and requirements at the beginning of the project, including timelines and key milestones. PMO will report to Board of Managers and if there are issues concerning deadlines, resources will be applied to verify targets are met.

Without dedicated, supporting MCC IT leadership and staff, there will be significant delay in deployment of the infrastructure, IDS, HIE, and data analytics systems; as a result analytics and clinical data required to improve quality of care and obtain desired community outcomes will not be available. Engage MCC IT resources by DY1, Q2.

MCC needs to assign responsibility for IT security and privacy and draft a charter/policies/procedures. Without these policies and procedures, infrastructure might be non-compliant with state or federal regulations. A member of MCC staff will be assigned duties of Privacy/Security Officer to ensure systems and interfaces meet regulations and develop/obtain consensus on security controls in use by all PPS members.

EHR solution is not affordable by providers. Without an EHR or access to one, providers will not be able to leverage the information delivered by the IDS, HIE, and data analytics. Secure value-based performance contracts which provide bonus payments for use of EHR system.

IT security tools cannot be designed until EHR adoption and IDS solution is implemented. IT security tools need to be implemented first so that they are imbedded in the architecture of the IT solutions. Those with duties/roles related to MCC privacy and security will be involved with all architecture and design solutions for EHR and IDS.

Disparate IT systems being used by partners could cause a delay in integration. The IT solution has to address multiple EHRs and provider data repositories. This includes a tiered approach to deployment of connectivity and integration of provider EHR and data repositories, dependent upon individual capabilities.

EHR vendors may not support interoperability with the RHIO at a reasonable cost, slowing implementation. Have representatives from the IT Data Committee participate in regional, state, and national conversations on this issue; apply pressure to the industry to actively support free flow of patient data.

Data is not consistent across practices and EHR vendors. This affects providers trying to interpret data from other practices and impedes population health analytics. Include EHR data standards implementation in with practice support services. Implement a data standardization/validation function.

To address cost constraints by PPS members and partners to purchase needed technology or connectivity, any IT solutions for providers must have a low cost per patient charge. Partner incentives must be structured to compel providers and PPS partners to implement the proposed solutions.

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Possible conflicts from administration of services from overlapping WNY PPSs. MCC will verify that all basic clinical patient data is flowing appropriately to and from the RHIO so patient data will be available to any provider regardless of PPS affiliation. If all WNY PPSs follow this model, delivery of the required and relevant information will benefit all and assist in delivery of desired goals and outcomes.

HEALTHeLINK and MCC training/support staff operate independent of each other. Multiple, uncoordinated outreach can cause confusion or distrust. Active, up-front coordination of activities to embed engagement of HEALTHeLINK services into the broader PPS practice transformation service.

Local HIE cannot meet requirements of the MCC HIE. Complete HIE gap analysis. Approach HEALTHeLINK with a contract to deliver on specific requirements.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

All workstreams are impacted by IT. Performance reporting and population health management in particular are nearly impossible without the technology in place to support them. In addition, all projects require participating providers to track patients using electronic systems. Many of the projects also require providers to not only have an EHR system in place, but to achieve MU and/or Patient-Centered Medical Home (PCMH) status. This will require extensive support and infrastructure from the central PPS IT organization.

Workforce: While technology can enable change, it is essential that the workforce strategy is defined and in place to support PPS membership through the required change. In addition, the clinical advisory committee will provide oversight and guidance in the design and development of the IDS, HIE, and data analytics systems and programs. This is to verify the IT solutions will be able to assist providers, partners, and organizations deliver on their desired outcomes and goals.

Clinical integration: Providers will need help in their offices to make this transformation, as well as receive ongoing support to sustain changes and deliver results.

Governance: The MCC leadership and governance structure has to be in place before IT processes and security/privacy policies can be finalized and approved.

Financial sustainability: Following initial implementation, it will be imperative that the PPS become financially sustainable so that the continuing costs of additional and updated IT assets can be met.

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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
MCC Administrative Director	Gregory Turner	Set current and future MCC IT strategy; oversee MCC IT operations; deliver on a day-to-day basis; remediate identified IT risks and elevate to IT Data Committee and MCC governance where appropriate
MCC Compliance Officer	Laura Fleming	Implement compliance controls and compliance program; oversee MCC privacy/security and IT change management platform
MCC IT personnel (various titles)	New hire(s)	Architect and design data exchange and interface topologies and strategies within MCC partners and members and with external entities; develop database architecture and environment for MCC; provide operational support, integration, and interoperability with MCC partners and external data sources; manage infrastructure teams; support IT architecture and systems
MCC IT privacy/security staff	To be assigned	Implement privacy/security controls and standards; monitor security controls including data security and confidentiality plans and strategy; monitor security controls; manage IT change management program; report to MCC Compliance Officer
IT TOM Development Team	From MCC: Bob Vail, John Cumbo, Priti Bangia, John J. Bono, Gregory Turner	Ensure IT initiatives align with MCC's IT TOM plan and support MCC's business and strategic vision
Clinical/Quality Committee	Co-chairs: Michael Cummings MD (UBMD Psychiatry); Joanne Haefner FNP (Neighborhood Health Center)	Provide input and guidance to IT strategy and development and design of IDS, HIE, and data analytics systems
IT Data Committee	Gregory Turner, John J. Bono, Anthony Billittier MD, Michele Mercer RN, HEALTHeLINK representatives, Community Partners of WNY (led by Catholic Medical Partners) representatives, Vicki Landes (NFMMC health home), Gail Mayeaux (Universal Primary Care)	Oversee IT program including approval of IT strategy and verification of appropriateness of vendor relationships; develop and adopt IT strategies; monitor progress and delivery to IT systems project deadlines; provide assistance if deadline or timelines are in jeopardy; remediate identified IT risks and elevate where appropriate; oversee IT Change Management Strategy
MCC Chief Integration Officer	Michele Mercer RN	Establish business and functional direction of integrated delivery model

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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		
Board of Managers (chair: Anne Constantino, Horizon Health)	Executive governance	Address risks identified by IT Data Committee
"Voice of the Consumer" Sub-Committee	Community participation	Encourage awareness of cultural norms; support diversity; provide feedback on training and other materials
All participating organizations	Full participation	Connect to other MCC providers in order to coordinate care across the region, support ongoing interconnectivity enhancements
PPS partner IT security representatives	Varies by organization	Verify and approve security controls and data exchange requirements
Data analysis tool vendors/staff (e.g., patient activation, HEDIS, population health, 3M, Coordination of Care, etc.)	Data analytics	Support use of data analysis tools at the central PPS level as well as at individual practices (as appropriate), ensure software is tested and meets MCC needs
External Stakeholders		
RHIOs (HEALTHeLINK, Rochester, etc.)	Data sharing, connectivity	Provide community-wide exchange of patient data, facilitate patient consent, provide connectivity to the SHIN-NY; assigned as guests to IT Data Committee; assist Clinical Integration Officer in an advisory capacity
Specialized software user groups (e.g., EHRs)	Support	User support
External consulting groups	Technical support	Provide technical expertise, staff, and services as needed to assist in meeting MCC objectives
NYS Health Commerce System/MAPP	Reporting	Provide consistent reporting capabilities
Patients, families, caregivers	Care seekers, data owners	Consent to share data across MCC providers/partners; utilize patient portals as available to engage in two-way communication with providers
SHIN-NY	Connectivity	Provide secure network for exchange of information across the state
WNY Rural Broadband Network	Telemedicine	Ensure rural communities are able to connect to broadband to facilitate telemedicine needs
Payers: Blue Cross Blue Shield; Independent Health; YourCare; Fidelis Care	Data communication	Share claims and provider data with MCC to assist in meeting and measuring project objectives

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Network connectivity providers	Connectivity	Ensure all members are able to connect to broadband to facilitate telemedicine needs
NY e-Health Collaborative	Strategic direction, IT tools	Provide continued support for IT initiatives (e.g., patient portal, statewide provider directory), establish statewide technical standards/policies that enable secure exchange of patient data
External databases (e.g., health homes, MAPP)	Data	Advance their systems to ensure appropriate connectivity to MCC activity and dashboards
Salient	Data	Provide clean, consistent Medicaid provider data
Departments of health and mental health from each MCC PPS county (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming)	Region-specific support and services	Communication to constituents of IT capabilities of DSRIP; provide access to social determinant data
NYS DOH, OMH, OASAS	State and federal support services	Review and determine regulatory waiver requests; provide IT data, security, and consent leadership

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IPQR Module 5.7 - Progress Reporting

Instructions :

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

Progress reporting will be aligned with the phased approach to implementing the overall IT systems and processes strategy. Success will be measured initially by finalizing appointments, staffing the IT Data Committee, and completing an IT current state assessment. These efforts will culminate into an EHR/IDS strategy; an implementation plan; an engagement strategy/plan; a data security and confidentiality plan; and an IT infrastructure development plan for interoperability, clinical integration, and population health management which will be used to report quarterly project- and unit-level progress.

The progress of MCC's IT system and processes efforts will be measured by:
Determining the current state assessment approach
Performing risk analysis and current state assessment of IT capabilities across MCC network
Aggregated, analyzed results of the assessment identifying gaps and areas of focus in the strategic plan
Establishing an IT governance structure representative of the entities in MCC, including reporting structure
Development of data security, confidentiality, IT strategy, IT implementation, and data governance plans
Development of a change management strategy and culture
A roadmap for achieving clinical data sharing and interoperable systems
Execution of legal requirements/documents for data sharing agreements
A comprehensive training plan to support implementation of new platforms
IT requirements and specifications for key data sharing across the IDS during transitions
Establishing reporting mechanisms to IT Data Committee and Board of Managers

Quarterly project- and unit-level reports will mark progress towards IT systems and processes strategy. These reports will include but are not limited to:
Reporting structure document
Regular audits of the change management process
MCC IT gap analysis results
Approved implementation plan
Approved change management strategy
Finalized/approved engagement strategy and plan
Approved MCC data governance plan
Data sharing policies and procedures document
Clinical interoperability system is in place for all participating providers
Approve roadmap with overarching rules of the road for interoperability and clinical data sharing
Approved plans for establishing data exchange agreements between all providers within the PPS
Equipment specifications (meeting certified standards for interoperability and communications) and rationale documented
Number of signed/executed DEAAs

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MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

IPQR Module 5.8 - IA Monitoring

Instructions :

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Section 06 – Performance Reporting

IPQR Module 6.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	In Progress	Performance reporting and communications strategy, signed off by PPS Board. This should include: -- The identification of individuals responsible for clinical and financial outcomes of specific patient pathways; -- Your plans for the creation and use of clinical quality & performance dashboards -- Your approach to Rapid Cycle Evaluation	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	NO
Task 1. MCC executive leadership will identify project leaders/managers for each project who will be responsible for progress and performance outcomes and program development.	Completed	1. MCC executive leadership will identify project leaders/managers for each project who will be responsible for progress and performance outcomes and program development.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. The Finance Committee and Workforce Development Work Group develop reporting plans that meet mandatory reporting and Rapid Cycle Evaluation (RCE) program goals.	In Progress	2. The Finance Committee and Workforce Development Work Group develop reporting plans that meet mandatory reporting and Rapid Cycle Evaluation (RCE) program goals.	08/03/2015	06/30/2016	08/03/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Complete interim plan for collecting performance and process data—including self-reported data from providers—and establish data quality standards and submission processes.	In Progress	3. Complete interim plan for collecting performance and process data—including self-reported data from providers—and establish data quality standards and submission processes.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. An interdisciplinary RCE support team will establish the goals and objectives of the RCE program and work hand in hand with provider champions, the Physician Performance Sub-	In Progress	4. An interdisciplinary RCE support team will establish the goals and objectives of the RCE program and work hand in hand with provider champions, the Physician Performance Sub-Committee, and the Clinical/Quality Committee.	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Committee, and the Clinical/Quality Committee.									
Task 5. Develop system for reporting early elective deliveries for project 3.f.i. Reduce Premature Births.	Completed	5. Develop system for reporting early elective deliveries for project 3.f.i. Reduce Premature Births.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 6. Establish an initial strategy for communicating baseline performance data available from existing DSRIP data sources (MAPP, Salient Interactive Miner) to partners via reports and scorecards.	In Progress	6. Establish an initial strategy for communicating baseline performance data available from existing DSRIP data sources (MAPP, Salient Interactive Miner) to partners via reports and scorecards.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Define a minimum data set required to support mandatory reporting as prescribed by the DOH and perform a comprehensive gap analysis of available and required data sources and reporting processes.	In Progress	7. Define a minimum data set required to support mandatory reporting as prescribed by the DOH and perform a comprehensive gap analysis of available and required data sources and reporting processes.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8. Develop comprehensive and audience-specific approaches to the phased implementation of internal reporting (between MCC and partners).	Not Started	8. Develop comprehensive and audience-specific approaches to the phased implementation of internal reporting (between MCC and partners).	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 9. Finalize initial policies and procedures for continuous and systematic data collection and rapid feedback including remediation strategies. These policies and procedures will be approved by the IT Data Committee and will comply with MCC's PPS-wide data governance and security plan.	Not Started	9. Finalize initial policies and procedures for continuous and systematic data collection and rapid feedback including remediation strategies. These policies and procedures will be approved by the IT Data Committee and will comply with MCC's PPS-wide data governance and security plan.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 10. Develop specifications for data collection, iterative reports, dashboards, scorecards, and other key deliverables.	Not Started	10. Develop specifications for data collection, iterative reports, dashboards, scorecards, and other key deliverables.	07/01/2016	12/30/2016	07/01/2016	12/30/2016	12/31/2016	DY2 Q3	
Task 11. Finalize data exchange agreements with Medicaid Managed Care Organizations (MCOs), RHIOs, and other participants with access to relevant data. These agreements will align with	Not Started	11. Finalize data exchange agreements with Medicaid Managed Care Organizations (MCOs), RHIOs, and other participants with access to relevant data. These agreements will align with RCE, quality improvement, and care management/population health program goals.	04/01/2016	12/30/2016	04/01/2016	12/30/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
RCE, quality improvement, and care management/population health program goals.									
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.	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3	NO
Task 1. Identify performance monitoring champions who will help lead and coordinate the dissemination of continuous messaging and facilitate the communication of feedback between individuals in the field and PPS leadership.	In Progress	1. Identify performance monitoring champions who will help lead and coordinate the dissemination of continuous messaging and facilitate the communication of feedback between individuals in the field and PPS leadership.	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 2. Provide initial pilot training to project team leads and project managers.	Not Started	2. Provide initial pilot training to project team leads and project managers.	04/01/2016	07/01/2016	04/01/2016	07/01/2016	09/30/2016	DY2 Q2	
Task 3. Perform a comprehensive assessment to identify key staff in compliance, reporting, training, and other roles.	Not Started	3. Perform a comprehensive assessment to identify key staff in compliance, reporting, training, and other roles.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 4. Form a training team responsible for developing performance monitoring and continuous quality improvement-specific training within the PPS's workforce training programs.	Not Started	4. Form a training team responsible for developing performance monitoring and continuous quality improvement-specific training within the PPS's workforce training programs.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 5. Include training materials and dissemination of performance monitoring information (on processes, outcomes, best practices, etc.) in PPS-wide communications plan.	Not Started	5. Include training materials and dissemination of performance monitoring information (on processes, outcomes, best practices, etc.) in PPS-wide communications plan.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 6. Define the training requirements required to develop and sustain a culture of performance reporting and quality improvement.	Not Started	6. Define the training requirements required to develop and sustain a culture of performance reporting and quality improvement.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 7. Evaluate and select evidence-based, best practice, and industry standard training materials as part of a coordinated training program.	Not Started	7. Evaluate and select evidence-based, best practice, and industry standard training materials as part of a coordinated training program.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task	Not Started	8. Provide pilot training to project team leads and project	10/31/2016	12/31/2016	10/31/2016	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
8. Provide pilot training to project team leads and project managers.		managers.							
Task 9. Create roll-out schedule for training to be held at various locations, including provider sites.	Not Started	9. Create roll-out schedule for training to be held at various locations, including provider sites.	10/31/2016	12/31/2016	10/31/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 10. Roll out PPS-wide training sessions.	Not Started	10. Roll out PPS-wide training sessions.	01/02/2017	12/31/2017	01/02/2017	12/31/2017	12/31/2017	DY3 Q3	
Task 11. Collect feedback using formal and informal surveys to assess training and messaging effectiveness.	Not Started	11. Collect feedback using formal and informal surveys to assess training and messaging effectiveness.	01/02/2017	12/31/2017	01/02/2017	12/31/2017	12/31/2017	DY3 Q3	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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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Milestone Review Status

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

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IPQR Module 6.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Performance data cannot be obtained from partner organizations because of technical (IT) roadblocks. If partner organizations lack the technical and human resources to accurately collect and transmit the required performance data in a timely manner, blind spots will form where we cannot measure our RCE metrics with confidence. This is mitigated at the earliest stages by identifying the data collection and sharing capabilities of PPS members. Once identified and a gap analysis is performed, we can begin our implementation with partners already sharing or prepared to share data. Concurrently, we will work with the overall Clinical Integration strategy to prioritize their inclusion in implementation plans.

Performance data cannot be obtained and normalized in a timely manner due to the implementation timeline and, therefore, reports cannot be submitted to the DOH on time. Early and aggressive efforts to enlist partners who can be champions for this effort. Also, the Physician Steering Committee and Physician Performance Sub-Committee will play key roles in establishing the need for timely reporting. Lastly, remediation strategies consistent with PPS bylaws will be implemented.

Performance data is obtained but is incorrect, incomplete, or corrupted. If data is delivered in non-standardized formats, the effort needed to acquire relevant data could surpass existing human and IT resources and lead to data with significant gaps and quality concerns. This may require additional resources for data extraction, transformation, and loading. Data reporting standards and practices must be defined in the policies and procedures and addressed in any project participation agreements with providers. A comprehensive data specification that aligns with data normalization and integration processes identified in the IT infrastructure strategy will be developed. Lastly, best practices for data extraction, transmission, and loading will be included in training and information materials developed to enrich a culture of performance monitoring.

Culture is resistant to change. A culture resistant to change or inundated with training requirements is less likely to deliver quality data, take the time to process findings from analyses, and implement continuous quality improvement projects. We will coordinate with the Workforce Development Work Group to streamline or better integrate performance improvement training into other education efforts, particularly those aimed at new staff. We will solicit input from provider organizations and project leads on how to better integrate performance reporting processes into existing workflows. Our communication and provider outreach teams will continuously reinforce the relationship between performance monitoring, funds flow, patient outcomes, and process improvement.

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.)

IT systems & processes: IT will serve as the backbone for data collection and reporting. IT systems must be designed to accommodate

performance reporting.

Clinical integration: Clinical integration facilitates the coordination of patient care across the PPS and drives improved outcomes that must be collected, analyzed, and reported through an effective performance reporting system.

Population health management: Performance reporting will provide for monitoring and assessment of population health performance, using outcomes to guide population health improvement activities.

Governance: The Board of Managers will be the ultimate entity responsible for ensuring that outcome data is used to determine incentive rewards.

Patient activation: Performance outcomes that will be reported from project 2.d.i. (Patient Activation) will determine the extent to which patient activation and motivation techniques leads to primary care connections for the uninsured and low and non-utilizing Medicaid beneficiaries.

Finance: The flow of funds provides immediate and irrefutable evidence of one key benefit of continuous quality measurement and improvement: the ability to see real dollar amounts attached to specific outcomes and goals. Funds flow also plays a significant role in dictating the speed and scale of project implementation, the ability to hire and retrain staff required to monitor and report on quality data, and the PPS's ability to meet the overall DSRIP goals.

Clinical quality: Performance reporting is closely linked with clinical quality in terms of both its goals and processes. Evidence-based medicine will guide the establishment, evaluation, and analyses of key performance metrics. These metrics will be established and approved through close coordination with the Chief Medical Officer, Physician Performance Sub-Committee, project leads, and other subject matter experts.

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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
MCC Chief Reporting Officer	John J. Bono	Oversee development and operation of an effective system for reporting and responding to process and performance outcomes; oversee and coordinate all reporting functions including data acquisition, report collection, specifications identification, and continuous quality improvement
MCC Administrative Director, data analysts, IT resources	Gregory Turner and various individuals	Implement reporting and communication technologies; provide hardware, software, networking, and security support for performance reporting, data collection, and analytics
Gatekeeper/IT Security Officer (ECMCC)	Robert Vail	Ensure compliance with all statutes and regulations for data handling, security, destruction, and access; coordinate HCS access with ECMCC
MCC Compliance Officer	Laura Fleming	Audit and monitor network to ensure objectives are being met
MCC Clinical Integration Officer	Michele Mercer RN	Establish performance goals; integrate population health and data tools into performance metrics
MCC Chief Medical Officer	Anthony Billittier MD	Define clinical metrics, liaise between medical community and MCC leadership
MCC Population Health Manager	Priti Bangia MSc MBA	Assist with development of population health metrics; monitor data and statistics necessary to prove outcomes
Physician Steering Committee	Chair: Frances Ilozue MD	Advise Board of Managers on clinical and quality issues; ensure physician community is represented and reports accurately reflect physicians and practices
Physician Performance Sub-Committee	Members of the Physician Steering Committee	Review provider metrics, determine remediation approach for under-performing providers
Rapid Cycle Evaluation (RCE) support team	Various individuals	Establish the goals and objectives of the RCE program
Performance monitoring champions	Various individuals	Coordinate with CRO, Physician Steering Committee, Clinical/Quality Committee, external stakeholders, and PMO to identify metrics, goals, and means to facilitate PPS-wide culture of performance monitoring and continuous quality improvement
MCC Director of Community-Based Initiatives	Catherine Lewis	Ensure community network has adequate access to computer systems to support reporting of results
Clinical/Quality Committee	Co-chairs: Michael Cummings MD (UBMD Psychiatry); Joanne	Provide subject matter expertise on measure identification and

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
	Haefner FNP (Neighborhood Health Center)	assessment; detect and address IT issues that may impede quality analysis

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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		
MCC Executive Director, Al Hammonds, Jr. CSSBB	Oversight	Ensure all reporting and measurement is meeting DSRIP objectives; ensure timely submission of all reporting
Physician Steering Committee Chair (Frances Ilozue MD)	Physician engagement	Ensure physician community is represented and reports accurately reflect physicians and practices
Finance Committee (Richard Braun, Mel Dyster, Colleen Muncy, Mike Sammarco, Chris Koenig, Raj Mehta, Lou Santiago, Christine Kemp, Gregory Turner, Sheila Kee, Kathrine Panzarella)	Finance reporting	Coordinate all reporting related to financial sustainability, budget, and funds flow
Governance Committee	Oversight	Approve proposed goals and objectives of MCC RCE program
IT Data Committee	IT coordination and data standards	Ensure performance monitoring and reporting meet industry standards; enable coordination of IT and data resources across PPS
All MCC practitioners	Engagement, reporting, acting on reports	Provide feedback on the effectiveness of training and reports; provide input on reporting needs relevant to their particular area of practice; participate in data collection activities and change management, including remediation
Workforce Development Work Group	Workforce reporting	Coordinate all reporting and data collection for hiring, training, reassignment, and other personnel-related initiatives; coordinate deployment of training in performance reporting and quality improvement
External Stakeholders		
Patients, families, caregivers	Data owners	Consent to exchange of data to facilitate accurate reporting across PPS
Local government agencies	Regulatory oversight	Support PPS reporting by considering regulatory waivers where needed
Local chapters of national professional societies and associations	Subject matter expertise	Provide input on reporting needs relevant to their particular area of practice
Medicaid MCOs: Blue Cross Blue Shield; Independent Health; YourCare; Fidelis Care	Data, expertise	Provide data on attributed recipients; advise on population health best practices; supply baselines for their population
HEALTHeLINK	RHIO/QE	Coordinate and collaborate on collection of EHR, CCD, and ADT

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
		data across the PPS and region; provide connectivity to SHIN-NY
New York State DOH	Regulatory body	Provide data required to identify attributed recipients; collect claims-based measures; report on all measures identified in Reporting Measures and Specifications Manual as DOH reporting responsibility

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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.

It is expected that the shared IT infrastructure will form the backbone of the performance reporting effort. As the central conduit for data flow both from and to the providers, it is essential that IT projects be coordinated with requirements for collecting performance data.

IT will be required for:

Data collection and transmission: Electronic health record, claims, and other data will have to be communicated securely and in a timely manner in adherence to the PPS data governance plan. Leveraging the RHIO to facilitate the exchange and delivery of encounter information will be crucial.

Data warehousing: Data, once collected, will have to be aggregated in a central location for analysis. This will require hardware, software, and technical expertise.

Data normalization and acquisition: Data acquisition across types and sources are all dependent on the IT infrastructure. Collaboration and coordination with other area PPSs as well as the local RHIO will further enhance performance improvement, regionally.

Communications infrastructure for transmitting reports to providers, the DOH, and key stakeholders: This includes the ability to host dynamic dashboards and, eventually, real-time streaming analytics. This will require resources such as web hosting, platform selection and acquisition, technical expertise from web services, or other development efforts.

Extract, transform, and load (ETL) processes and data integration: Effectively leverage data sources provided by NYS DOH via Salient Interactive Miner and the MAPP. Define ETL processes for making best use of that data and integrating it into internal PPS analytics, reports, and dashboards.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

Progress reporting will be aligned with the phased approach to implementing the overall performance reporting strategy. Establishment of project- and unit-level reporting frequency will be based on the internal and external reporting requirements to ensure the success of MCC-wide performance reporting strategy. Success will be measured initially by finalizing appointments, staffing the Clinical/Quality Committee, and completing a comprehensive network assessment. The progress of MCC's performance reporting and communications efforts will be measured by

a performance reporting and communications strategy approved by the Board of Managers.

The strategy will at minimum include the following:
Roles and responsibilities
Creation of clinical and quality dashboards
Defined RCE approach
Creation of RCE support team
Policies and procedures for continuous and systematic data collection and rapid feedback including remediation strategies approved by Board of Managers
A reporting schedule aligned with finance, governance, and cultural competency/health literacy
A comprehensive training program

Overall project- and unit-level reports to mark progress towards performance reporting and communication will include but are not limited to:
RCE support team meeting schedule and minutes
RCE goals
Gap assessment results
Data collection policies and procedures
Reporting guidebook
Sample scorecard and report templates; examples of deliverables presented to partners
Training curriculum including materials
Participant/attendance record
Training outcomes

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

IPQR Module 6.9 - IA Monitoring

Instructions :

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Section 07 – Practitioner Engagement

IPQR Module 7.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop Practitioners communication and engagement plan.	In Progress	Practitioner communication and engagement plan. This should include: -- Your plans for creating PPS-wide professional groups / communities and their role in the PPS structure -- The development of standard performance reports to professional groups --The identification of profession / peer-group representatives for relevant governing bodies, including (but not limited to) Clinical Quality Committee	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	NO
Task 1. Hire practitioner engagement liaison to implement; direct; manage; monitor; and improve practitioner communication, engagement, empowerment, and ongoing relations.	Completed	1. Hire practitioner engagement liaison to implement; direct; manage; monitor; and improve practitioner communication, engagement, empowerment, and ongoing relations.	06/01/2015	12/31/2015	06/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Develop communication and engagement plan which addresses Domain 1 - MCC operations (logistical matters, non-patient interfaces, financial/funds flow, compliance, reporting); domain 2 - system transformation (population health management, clinical integration, connectivity, PCMH, care coordination/transitions); domain 3 - clinical transformation (quality improvement, standards of care, evidence-based best practices); and domain 4 - population health (public health projects related to NYS Prevention Agenda).	Not Started	2. Develop communication and engagement plan which addresses Domain 1 - MCC operations (logistical matters, non-patient interfaces, financial/funds flow, compliance, reporting); domain 2 - system transformation (population health management, clinical integration, connectivity, PCMH, care coordination/transitions); domain 3 - clinical transformation (quality improvement, standards of care, evidence-based best practices); and domain 4 - population health (public health projects related to NYS Prevention Agenda).	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 3. Create a comprehensive practitioner network registry to identify all potential practitioners (contact information, communication preferences, practice demographics, areas of expertise).	In Progress	3. Create a comprehensive practitioner network registry to identify all potential practitioners (contact information, communication preferences, practice demographics, areas of expertise).	09/01/2015	12/31/2015	09/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 4. Develop communication strategy utilizing technology (e.g. website, social media, etc.) to allow bi-directional, effective information sharing including provider feedback and recommendations to MCC.	In Progress	4. Develop communication strategy utilizing technology (e.g. website, social media, etc.) to allow bi-directional, effective information sharing including provider feedback and recommendations to MCC.	06/01/2015	12/31/2015	06/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Establish professional advisory groups/communities as needed based on project initiatives and subject matter expertise (e.g., cardiovascular, diabetes, behavioral health). Identify and leverage professional peer groups/communities already active in the region.	In Progress	5. Establish professional advisory groups/communities as needed based on project initiatives and subject matter expertise (e.g., cardiovascular, diabetes, behavioral health). Identify and leverage professional peer groups/communities already active in the region.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6. Adopt communication strategies that address physicians' reluctance to participate. Utilize consensus-building techniques to maximize practitioner buy-in and ownership of DSRIP efforts.	In Progress	6. Adopt communication strategies that address physicians' reluctance to participate. Utilize consensus-building techniques to maximize practitioner buy-in and ownership of DSRIP efforts.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Encourage meaningful and effective engagement through meaningful incentives such as CME credits.	In Progress	7. Encourage meaningful and effective engagement through meaningful incentives such as CME credits.	07/01/2015	12/30/2016	07/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task 8. To achieve more effective interaction, collaborate with payers and other entities similarly trying to engage and influence practitioner behaviors.	In Progress	8. To achieve more effective interaction, collaborate with payers and other entities similarly trying to engage and influence practitioner behaviors.	05/01/2015	12/31/2015	05/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 9. Engage MCC's geographic councils (Niagara Orleans Healthcare Organization, Southern Tier Council) to ensure practitioners from all areas of	Completed	9. Engage MCC's geographic councils (Niagara Orleans Healthcare Organization, Southern Tier Council) to ensure practitioners from all areas of PPS are included and represented.	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
PPS are included and represented.									
Task 10. Draft Practitioner Communication and Engagement Plan.	In Progress	10. Draft Practitioner Communication and Engagement Plan.	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 11. Obtain feedback on draft Practitioner Communication and Engagement Plan from practitioner groups.	In Progress	11. Obtain feedback on draft Practitioner Communication and Engagement Plan from practitioner groups.	11/02/2015	03/31/2016	11/02/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 12. Revise Community Engagement Plan based on input and feedback gathered. Provide final draft to MCC governance for review.	In Progress	12. Revise Community Engagement Plan based on input and feedback gathered. Provide final draft to MCC governance for review.	12/01/2015	06/30/2016	12/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 13. Obtain approval of Practitioner Communication and Engagement Plan.	Not Started	13. Obtain approval of Practitioner Communication and Engagement Plan.	05/01/2016	06/30/2016	05/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 14. Begin distribution of performance reports to professional groups as appropriate. Maintain records of communications sent and other evidence of active engagement.	Not Started	14. Begin distribution of performance reports to professional groups as appropriate. Maintain records of communications sent and other evidence of active engagement.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 15. Begin ongoing process of obtaining feedback on reports provided to professional groups.	Not Started	15. Begin ongoing process of obtaining feedback on reports provided to professional groups.	01/01/2016	06/30/2016	01/01/2016	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.	05/01/2015	09/30/2016	05/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Practitioner engagement liaison will coordinate with MCC Communications Director to orchestrate the provision of initial, introductory training to MCC partners and the community. Oversight will be provided by MCC Chief Clinical Integration Officer and Chief Medical Officer, with guidance from the Physician Steering Committee.	Completed	1. Practitioner engagement liaison will coordinate with MCC Communications Director to orchestrate the provision of initial, introductory training to MCC partners and the community. Oversight will be provided by MCC Chief Clinical Integration Officer and Chief Medical Officer, with guidance from the Physician Steering Committee.	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 2. Leveraging the training needs list compiled in the Workforce workstream (milestone #5), identify additional educational needs for DSRIP practitioners related to quality of care, standards of care, and other healthcare delivery.	In Progress	2. Leveraging the training needs list compiled in the Workforce workstream (milestone #5), identify additional educational needs for DSRIP practitioners related to quality of care, standards of care, and other healthcare delivery.	07/01/2015	12/31/2015	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 3. Define requirements and process for initial and ongoing practitioner education programs. Programs may be purchased, developed internally, and/or created (in partnership with clinical experts, healthcare educational institutions, and education subject matter experts).	Not Started	3. Define requirements and process for initial and ongoing practitioner education programs. Programs may be purchased, developed internally, and/or created (in partnership with clinical experts, healthcare educational institutions, and education subject matter experts).	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Begin development of DSRIP program-specific educational initiatives.	In Progress	4. Begin development of DSRIP program-specific educational initiatives.	05/01/2015	03/31/2016	05/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. Begin implementation of DSRIP program-specific educational initiatives.	In Progress	5. Begin implementation of DSRIP program-specific educational initiatives.	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 6. On an ongoing basis, collect, collate, and prioritize educational needs from MCC staff and practitioners.	In Progress	6. On an ongoing basis, collect, collate, and prioritize educational needs from MCC staff and practitioners.	05/01/2015	06/30/2016	05/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 7. Begin ongoing process of obtaining feedback on education.	In Progress	7. Begin ongoing process of obtaining feedback on education.	05/01/2015	09/30/2016	05/01/2015	09/30/2016	09/30/2016	DY2 Q2	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	The practitioner engagement plan is in an outline form and in development. The draft will be circulated to the Clinical Quality Committee and the Physician Steering Committee for feedback in the month of March. Tasks 3-4 are dependent on CRM implementation/provider database completion.
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.	The practitioner training and education plan is in development while concurrently piloting different forums to deliver DSRIP and PPS information. A formal CME schedule is being developed along with a practice engagement strategy to give practitioners the option of group meetings or more personal settings to consume information. Task 2 is dependent on Workforce survey.

Milestone Review Status

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

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IPQR Module 7.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Practitioners receive continuous and extensive external personal and professional communications from multiple sources; addition of DSRIP communications could further overwhelm these already busy individuals. Uniquely engage, incentivize, and provide value-add to help ensure meaningful and effective engagement. Consider small financial incentives, free Continuing Medical Education (CME) credits, office detailing used by pharmaceutical and medical equipment representatives, dinners, and other innovative methods. Engage other entities similarly trying to engage and influence practitioner behaviors (e.g., payers). Partner/collaborate with like-minded entities to leverage strength in numbers, share costs and resources, and ultimately achieve more effective interaction.

Practitioners may disagree and/or take offense with, and perhaps actively resist DSRIP initiatives (e.g., established standards of care and quality of care reporting) which could be viewed as encroachment in the doctor-patient relationship. Make every effort to ensure inclusivity, transparency, evidence-based justification, and other consensus-building techniques to maximize practitioner buy-in and ownership of DSRIP efforts and the DSRIP program itself.

The MCC network includes a wide range of types of practitioners and participants, and serves a diverse patient population across a large and varied geographical area. There is potential fragmentation among physicians and between community resources and physicians. Providers in other areas feel this is an Erie County initiative and their voices are not being heard. Maintain a physical and virtual presence. Engage geographic councils to ensure the Southern Tier and Niagara/Orleans counties are represented.

MCC practitioners vary greatly in terms of the level of resources available to them. For example, practices that have already achieved Patient-Centered Medical Home (PCMH) certification will be in a much better position to meet DSRIP project requirements (e.g., exchange patient data via EHR) than those practices that are understaffed, and those located in areas without robust community-level resources available. These disadvantaged practices will struggle to implement the same strategies in the time allowed. Allocate resources to fill in gaps. Offer meaningful incentives (cash, workforce, or equipment). Provide IT support, software, hardware, and/or videoconferencing capability. Provide onsite outreach. Engage practitioners virtually via social media, EHR alerts, virtual CME, and videoconferencing. Provide resources through HEALTHeLINK.

There is considerable county overlap with two adjacent PPSs in WNY. Among practices there are varying degrees of clinical standards, especially in outpatient/primary care. The patient experience should be relatively uniform regardless of PPS. Ultimately it would be ideal across the PPS (and the region) to achieve consensus on clinical guidelines/protocols. Minimally we want to ensure uniformity to create a seamless experience for the patient, regardless of where he or she seeks care. PPSs will agree to share registry information, use standardized referral protocols, utilize uniform tracking and reporting systems and procedures, and maintain common messaging to educate/communicate with patients. MCC will work with Finger Lakes PPS and Community Partners of WNY (led by Catholic Medical Partners) to establish common protocols for referrals (inside or outside the PPS).

IPQR Module 7.4 - 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.)

IT Systems & Processes: IT capabilities will be central to the achievement of major practice/workflow transformations related to PCMH. Specific to practitioner engagement, we will need a technical solution (platform) to engage physicians and share PPS-wide and practice-specific information/messaging. This may involve utilizing existing channels (such as social media) and developing new ones that meet the participants' needs. We will establish two-way communication and use a virtual presence to share information about different workstreams within the PPS. We will host regularly scheduled virtual meetings. To communicate and share lessons learned with physicians across the state, we will encourage practitioners to use MIX (or other state-provided venues, as appropriate).

Performance Reporting: It will be critical to implement dashboards for monitoring at a central level as well as self-monitoring at the practice level.

Governance: Make certain physicians are involved in decision-making. Have physicians in different specialties (e.g., pulmonary, cardiology, etc.) review clinical guidelines. These could be ad hoc or limited-time sub-committees, formed as required.

Finance and Flow of Funds: Performance is tied to finance/flow of funds. Reduced funds flow due to lackluster or nonperformance will be passed through from PPS to practitioners, potentially resulting in practitioners not getting paid.

Workforce: Workforce redevelopment strategy involves significant redeployment and retraining.

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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
MCC Chief Medical Officer	Anthony Billittier MD	Ensure policies affecting physicians are evidence-based guidelines selected with sound medical judgment; serve as provider liaison
Practitioner engagement liaison	Jillian Barone	Implement; direct; manage; monitor; and improve practitioner communication, engagement, empowerment, and ongoing relations
MCC Clinical Integration Officer	Michele Mercer RN	Ensure providers and their support staff are aware of DSRIP policies and clinical workflows
Physician Steering Committee	Chair: Frances Ilozue MD	Ensure MCC physicians are represented and support decisions
MCC Communications Director	Kelly Showard	Coordinate with practitioner engagement liaison to implement effective outreach strategies specifically targeted at practitioners
Geographic councils	Niagara Orleans Healthcare Organization (led by Sheila Kee, Niagara Falls Memorial Medical Center) and Southern Tier Council (led by Richard Braun, Olean General Hospital)	Implement practitioner engagement strategies in the Northern and Southern Tier counties of the PPS; report progress, challenges, and appropriate solutions to the Physician Steering Committee

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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		
All MCC practitioners	Participants	Engage in MCC projects, deliverables, and action plans
Primary care safety net practices (including SNAPCAP, VAP)	Participants	Engage safety net practices in the MCC projects, deliverables, and action plans
Primary care private practices	Participants	Engage in MCC projects
"Voice of the Consumer" Sub-Committee	Advisory	Ensure patients', families', and caregivers' voices are heard in relation to all MCC activities
Community-Based Organization (CBO) Task Force	Advisory, training	Ensure community action plans are in line with community needs; ensure selected CBO institutions are appropriate for MCC initiatives
Regional Perinatal Center of WNY	Education/training	Education of OB/GYN on use of progesterone etc.
External Stakeholders		
Local chapters of national professional societies and associations (e.g., Buffalo Chapter of National Association of Black Social Workers)	Training, outreach	Education to members regarding MCC initiatives
ASAP and NYS Council for Community Behavioral Healthcare	Regulatory oversight	Regulatory waivers
Rural health networks	Outreach	Ensure rural physicians' communication and action plans are aligned with MCC initiatives
NY Care Coordination Program (Rochester), Departments of Mental Health	Training	Regional training
Nursing organizations	Training	Nursing education
Labor partners	Outreach	Encourage buy-in and engagement from nurses and other practitioners
Patients, families, caregivers (via groups like the Parent Network of WNY)	Advocacy	Help providers understand importance of DSRIP initiatives
Physician groups/clubs (e.g., P2 Collaborative of WNY, HEALTHeLINK Physician Committee)	Outreach	Encourage buy-in and engagement from physicians
HEALTHeLINK	RHIO	Ensure providers in network are gathering consent and information is flowing across network

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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.

IT capabilities to achieve major practice/workflow transformations related to PCMH

Physician participation in the development of the IT strategy and implementation plan

Technical platform to engage physicians and share PPS-wide and practice-specific information/messaging; this may involve utilizing existing channels (such as social media) and developing new ones that meet PPS needs

Easy-to-use reporting systems for practices to submit quality data; dashboard technology to share/display performance data

Patient and provider portals to facilitate communication and data sharing among providers and between providers and patients

Teleconferencing, videoconferencing, and other technology capabilities to support effective two-way communication with providers dispersed across a broad geographical area, including those with limited access to broadband

Connectivity through HEALTHeLINK, integration with EHR systems to support sharing of data across the region

Technical support and training for practices related to use of PPS-specific tools (e.g., reporting interface), RHIO connectivity/capabilities, data collecting and reporting practices, EHR/Meaningful Use, PCMH certification

IPQR Module 7.8 - Progress Reporting

Instructions :

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

Progress reporting will be aligned with the phased approach to implementing the overall practitioner engagement strategy. Project success and governance will be measured by the penetration within the provider community.

As the practitioner engagement strategy is developed, quarterly progress reports will include:
Hiring of a practitioner engagement liaison responsible for practitioner communication, engagement, empowerment, and ongoing relations
Development of a comprehensive practitioner network registry
A Practitioner Communication and Engagement Plan to be reviewed and approved by MCC governance

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A regular meeting schedule; meeting minutes
Comprehensive practitioner training strategy to address MCC quality improvement agenda and continuing DSRIP education

Quarterly reports will track the progress of practitioner network development, implementation, and education against project goals. Reports will include analyses of, but not be limited to, the following:
Number of practitioners in the network
Primary care capacity for both safety net and non-safety net organizations
Number of practitioners by groupings (e.g., cardiovascular, diabetes, behavioral health)

The progress of the practitioner engagement training/education plans will be analyzed and reports will be developed to assess the following:
Number of training programs delivered each quarter
Geographical locations of trainings
Number of participants per training session
Percentage of practitioners who completed training
Training satisfaction rate

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Develop population health management roadmap.	In Progress	Population health roadmap, signed off by PPS Board, including: -- The IT infrastructure required to support a population health management approach -- Your overarching plans for achieving PCMH 2014 Level 3 certification in relevant provider organizations --Defined priority target populations and define plans for addressing their health disparities.	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1	NO
Task 1. Finalize requirements for population health management and other business intelligence tools.	Completed	1. Finalize requirements for population health management and other business intelligence tools.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Identify data sources and inputs required to appropriately collect and process data for analytics.	Completed	2. Identify data sources and inputs required to appropriately collect and process data for analytics.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 3. Establish IT requirements for initializing, maintaining, and communicating risk stratification across settings with electronic interfacing to the participating provider community.	In Progress	3. Establish IT requirements for initializing, maintaining, and communicating risk stratification across settings with electronic interfacing to the participating provider community.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. IT requirements for key data sharing across the integrated delivery system (IDS) during transitions including interface with overlapping PPSs in the WNY region.	In Progress	4. IT requirements for key data sharing across the integrated delivery system (IDS) during transitions including interface with overlapping PPSs in the WNY region.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	In Progress	5. Issue request for proposals or other action step for	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
5. Issue request for proposals or other action step for population health tools. Select vendor or implement other structure for population health and data analytics tools.		population health tools. Select vendor or implement other structure for population health and data analytics tools.							
Task 6. Select evidence-based care management model(s).	In Progress	6. Select evidence-based care management model(s).	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 7. Develop strategy for primary care transformation (PCMH 2014 level 3 certification) as outlined in project 2.a.i. (requirement #7).	In Progress	7. Develop strategy for primary care transformation (PCMH 2014 level 3 certification) as outlined in project 2.a.i. (requirement #7).	05/01/2015	09/30/2016	05/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 8. Define business requirements for risk stratification methodology (high risk, moderate risk, low risk, and well) and pilot test risk criteria.	In Progress	8. Define business requirements for risk stratification methodology (high risk, moderate risk, low risk, and well) and pilot test risk criteria.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 9. Produce patient registries based on risk stratification methodology.	In Progress	9. Produce patient registries based on risk stratification methodology.	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 10. Define priority target population, building upon PPS project requirements and the Community Needs Assessment.	In Progress	10. Define priority target population, building upon PPS project requirements and the Community Needs Assessment.	04/01/2015	12/30/2016	04/01/2015	12/30/2016	12/31/2016	DY2 Q3	
Task 11. Compile information from steps above into Population Health Roadmap draft.	In Progress	11. Compile information from steps above into Population Health Roadmap draft.	07/01/2015	12/31/2015	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 12. Submit draft Population Health Roadmap draft to MCC Board of Managers for review/approval.	Not Started	12. Submit draft Population Health Roadmap draft to MCC Board of Managers for review/approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 13. Identify priority practices to work with based on readiness.	Not Started	13. Identify priority practices to work with based on readiness.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 14. Operationalize population health IT infrastructure, processes, and procedures based on requirements.	Not Started	14. Operationalize population health IT infrastructure, processes, and procedures based on requirements.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task 15. Implement and deploy population health	Not Started	15. Implement and deploy population health strategy and tactical plan, including clinical resources and data analytics	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
strategy and tactical plan, including clinical resources and data analytics tools and environment leveraging data from the MCC integrated EHR and data exchange/HIE environments.		tools and environment leveraging data from the MCC integrated EHR and data exchange/HIE environments.							
Task 16. Measure, improve, and refine population health management processes.	Not Started	16. Measure, improve, and refine population health management processes.	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1	
Task 17. Track and monitor progress of implementation of the Population Health Roadmap to verify continuous improvement.	Not Started	17. Track and monitor progress of implementation of the Population Health Roadmap to verify continuous improvement.	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1	
Milestone #2 Finalize PPS-wide bed reduction plan.	Not Started	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.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1. Complete review (fact-based data collection) of medical/surgical inpatient bed capacity in hospitals and skilled nursing facilities (SNFs).	Not Started	1. Complete review (fact-based data collection) of medical/surgical inpatient bed capacity in hospitals and skilled nursing facilities (SNFs).	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 2. Complete review of behavioral health inpatient bed capacity.	Not Started	2. Complete review of behavioral health inpatient bed capacity.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 3. Review ED and CPEP referrals from external sources, volumes, and wait times in order to evaluate inpatient need.	Not Started	3. Review ED and CPEP referrals from external sources, volumes, and wait times in order to evaluate inpatient need.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 4. PPS-wide Bed Reduction Work Group analyzes current state, DSRIP impact on capacity, and bed redesign by sub-region.	Not Started	4. PPS-wide Bed Reduction Work Group analyzes current state, DSRIP impact on capacity, and bed redesign by sub-region.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task 5. Develop recommendations for excess bed reduction.	Not Started	5. Develop recommendations for excess bed reduction.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 6. Obtain Board of Managers approval on bed reduction plan.	Not Started	6. Obtain Board of Managers approval on bed reduction plan.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Task 7. Begin quarterly reporting on bed reductions and delivery of bed reduction plan.	Not Started	7. Begin quarterly reporting on bed reductions and delivery of bed reduction plan.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop population health management roadmap.	Tasks #1-2 are complete.
Finalize PPS-wide bed reduction plan.	

Milestone Review Status

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

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IPQR Module 8.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Excess bed capacity. MCC hospitals have an occupancy rate of 71% that translates into 511 beds not in use, and the NYS DOH projected (2016) 499 excess beds for residential healthcare facilities in WNY. Resolve excess bed capacity in inpatient and SNF facilities by in-depth fact-finding followed by a collective recommendation process and phased-in implementation.

Gaps in RHIO interoperability. Enhanced communication and care management data sharing among primary care and specialists, mental health, health homes (HHs), and community support agencies does not exist, and the interoperability among hospitals and pharmacies needs to be enhanced. There is a lack of universal protocols across settings. We lack an interoperable HIE to make care management data accessible in real time. Activate a continuum of providers in the IDS including medical, behavioral, and community to increase HIE use and area-wide patient consent along with massive RHIO enhancements to support population health management in the PCMH connected across settings.

Gaps in primary care infrastructure. PCMH/APCM status is low within MCC, with only 36% of primary care locations (85 out of 235) currently NCQA recognized as PCMH facilities. Achieve PCMH/APCM standards and MU requirements in all safety net primary care locations. Achieve EHR connectivity to RHIO's HIE for all safety net primary care locations. Achieve health IT integrated population health management in all safety net primary care locations.

Gaps in PCP settings. There are virtually no PCP personnel devoted exclusively to care management of the high-risk complex population associated with avoidable admissions and readmissions. Establish risk stratification built into the IDS. Embed new care management teams in safety net locations that provide care management services across settings between office encounters with the highest risk population. Engage patients in the IDS at all levels. Achieve real service integration with HHs.

Workforce competency gaps. A crucial component of population health management to achieve DSRIP goals will be establishing PCMH teams devoted exclusively to care management of the high-risk complex population associated with avoidable admissions and readmissions. The roles, responsibilities, skills, and competencies for this have not yet been defined. We will address these gaps by building training into the practice transformation process used by the primary care locations in the MCC network to achieve PCMH 2014 recognition.

Barriers to patient engagement in population self-management. Broadly, we will engage patients in the IDS at all levels. Operationally, we will embed patient engagement and activation into the practice transformation process used by primary care locations in the MCC network to achieve PCMH 2014 recognition.

Failure of the multiple PPS organizations in WNY to cooperate through the use of common protocols, standardized reporting requirements, and sharing lessons learned will negatively impact the primary care transformation process because providers will become confused by inconsistent or even contradictory instructions that will impede their performance. MCC, Community Partners of WNY (led by Catholic Medical Partners), and the Finger Lakes PPS will hold routine meetings and share information and ideas. Wherever possible, the three PPS organizations will develop standards and procedures that will guide implementation of the population health roadmap in a unified way.

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Attributed patients do not provide consent to allow sharing of clinical data, causing inaccurate data analytics and population health information and an inability to provide quality, coordinated care for the community. Develop materials to outline benefits of sharing clinical data and require all patient access points to educate and capture patient consent documents.

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.)

Population health management that is capable of reducing avoidable admissions and readmissions is highly dependent on all elements of the PPS.

Population health management is dependent upon PPS-wide clinical integration and protocol for defining risk stratification so that care management intensity and scope is stepped according to level of patient need.

Interoperability across settings for population health is dependent upon massive IT/HIE systems and processes enhancements.

Population health management of high-risk panels must be high-touch and active across settings using new roles and responsibilities that are not found in encounter-based, office-based care. To be effective, the new high-risk care management must function outside the office under the direction of the PCMH. This new out-of-office intensive care management is not currently covered by encounter-based reimbursement, so it is highly dependent upon financial sustainability through value-based payments.

Population health management is dependent upon a trained primary care, behavioral health, and HH workforce and, therefore, must rely on the expertise, planning, and work of the workforce workstream.

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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
IT Data Committee	Gregory Turner, John J. Bono, Anthony Billittier MD, Michele Mercer RN, HEALTHeLINK representatives, Community Partners of WNY (led by Catholic Medical Partners) representatives, Vicki Landes (NFMMC health home), Gail Mayeaux (Universal Primary Care)	Identify sources of data
MCC Chief Integration Officer	Michele Mercer RN	Establish performance goals, integrate population health and data tools into performance metrics
Physician Steering Committee	Chair: Frances Ilozue MD	Implement strategy for ensuring physician engagement
Chief Medical Officer	Anthony Billittier MD	Oversee strategy for ensuring physician engagement
Physician Performance Sub-Committee	Members of Physician Steering Committee	Review provider metrics, determine remediation approach for under-performing providers
MCC Administrative Director, data analysts, IT resources	Gregory Turner and various individuals	Implement reporting and communication technologies, risk stratification, and data sharing across PPS
Governance Committee	Various individuals	Establish goals and objectives of MCC Rapid Cycle Evaluation (RCE) program with assigned representation from Physician Performance Subcommittee and Clinical/Quality Committee
Clinical/Quality Committee	Co-chairs: Michael Cummings MD (UBMD Psychiatry); Joanne Haefner FNP (Neighborhood Health Center)	Develop clinical metrics and processes to support accountability for population outcomes
MCC Population Health Manager	Priti Bangia MSc MBA	Develop clinical and community metrics for projects, support the community in education and implementation of population health techniques, work closely with clinical integration and IT business owners, monitor/ensure all metrics from the community are uploaded in a clean, secure manner allowing for accurate reporting and data collection
Other MCC staff/population health team	To be designated	Support/educate community providers on conducting and uploading population health data for successful reporting
MCC care transition coordinators	To be designated	Support outreach to patients and complete necessary metrics to measure effectiveness
Population health vendor(s)	To be selected by RFP	Supply systems that support population health management, execution, and measurement
Workforce Development Work Group	R-AHEC	Provide guidance and training/retraining as needed in relation to

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Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
		the PPS-wide bed reduction plan

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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		
Primary care practices	Care providers	Reduce avoidable admissions, ensure high-risk patients are monitored according to care plan, prevent patients from entering high-risk populations by deploying prevention and medicine based on evidence-based guidelines
Hospital/emergency department (ED) discharge staff	Care transition	Follow approved policies and procedures, especially when discharging high-risk patients; link all patients to PCPs and secure appointments
ED care coordinators/navigators	Care coordination	Intercept high-risk patients, follow approved protocols to identify and remove barriers to care
Community-Based Organization (CBO) Task Force	Patient outreach	Coordinate medically-appropriate and culturally-sensitive interventions with high-risk patients
MCC Administrative Director (Gregory Turner)	Lead MCC IT strategy; coordinate with lead entity (ECMCC) for IT alignment	Ensure IT solution meets clinical integration and population health business requirements
External Stakeholders		
Urgent care centers	Care access, care coordination	Ensure communication to PCPs, contribute to coordination of care
Health homes (adult and pediatric)	Care coordination	Document interventions and care coordination activities for sharing among health homes to manage populations holistically and enhance reporting
Health plans and Medicaid managed care organizations	Risk management	Risk stratification
CBOs	Patient outreach	Deploy resources to intervene with high-risk patients, follow approved protocols to identify and remove barriers to care
P2 Collaborative of WNY	Education	Educate patients and providers
Rural health networks	Patient outreach, care coordination	Ensure rural populations are supported by MCC and care is rendered
Pharmacies	Education	Educate patients and providers
School-based health services	Care access, care coordination	Provide improved access to care for school-aged population to prevent them from entering high-risk groups, connect students (and families) with primary care

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
All health service providers and community-based services	Community services	Community support of population health
Retail-based medical services ("minute clinics")	Care access	Provide medical services (including vaccinations) especially for uninsured or low utilizing patients in the community
HEALTHeLINK	Connectivity	Provide communication platform for essential clinical data to manage populations
FQHCs	Population health	Support impoverished and uninsured populations to decrease risk and improve health

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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.

Maturation of the existing HIE. The HIE (HEALTHeLINK) is well developed in terms of its capability to collect data from hospitals, laboratories, and radiology facilities. Hospital data about admissions, discharges, and transfers is critical for identifying target populations and is available from every hospital in the region. However, population health interventions across an integrated delivery system, especially for high-risk patients, require bi-directional HIE in primary care, long-term care, and home care settings. While many primary care settings have access to read data from HEALTHeLINK, very few have the ability to feed data in so that it can be accessed in other settings. Long-term care settings currently have little connectivity. WNY was one of the first communities in the nation to establish HIE connections with home care but the data shared is limited. If these connections cannot be made in a timely fashion, there is a risk that coordination of care across the system for population health will be impaired. This will limit the ability to reduce hospitalizations. To mitigate this risk, we will encourage and support the use of Direct communication, which provides a means of secure clinical communication among organizations without the use of an HIE and therefore does not depend on the ability to create the bi-directional connections to the RHIO outlined above.

EHR implementation across the system is particularly problematic in long-term settings where EHR adoption has been slower than in other settings.

Integration of primary care and behavioral health: if it is not in place then population health efforts for patients with mental health and chronic disease will be much more difficult.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

Progress reporting will be aligned with the phased approach to implementing the overall population health management direction. Project success and governance will be measured by the establishment of a population health roadmap which identifies the IT infrastructure necessary to support data analytics for MCC including targeted patient registries and their care management which supports primary care transformation. MCC will track its performance on domain 2 and 3 metrics (for all projects) to measure improvement over DY1 baselines. Scores will be used to determine which aspects of the population's health to focus on and to track improvement of the population health related-metrics over time. The progress of population health management will be presented to the Clinical/Quality Committee on a monthly basis. This will then be reported from the Clinical/Quality Committee to the Board of Managers on a quarterly basis.

Progress towards the development and approval of this roadmap will be reported quarterly (projected timeline versus actual implementation

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timeline/percent complete of implementation of the approved roadmap). Quarterly reports will describe progress at the project and unit level including development of the population health management roadmap approved by the Board of Managers.

The roadmap will at minimum include the following items:
Development of physician and patient communication and education plans
RFP process for selection of vendor
Implementation and deployment of population health management data analytics tools
Development of business intelligence and other data analytics reporting at the project and unit levels
Communicating results of population health management to appropriate committees and sub-committees

Population health management project- and unit-level progress reports will measure the status of the following:
Population health roadmap designed to meet PCMH 2014 requirements and reduce avoidable utilization
Risk stratification criteria: definition of priority target population; rubric for risk stratification; pilot test of risk stratification criteria
Patient registries for risk stratification, pushed electronically to physicians
Percent of primary care offices submitting NCQA application for 2014 PCMH recognition
Percent of primary care offices obtaining NCQA 2014 PCMH level 3 recognition

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

IPQR Module 8.9 - IA Monitoring

Instructions :

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Section 09 – Clinical Integration

IPQR Module 9.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform a clinical integration 'needs assessment'.	In Progress	Clinical integration 'needs assessment' document, signed off by the Clinical Quality Committee, including: -- Mapping the providers in the network and their requirements for clinical integration (including clinical providers, care management and other providers impacting on social determinants of health) -- Identifying key data points for shared access and the key interfaces that will have an impact on clinical integration -- Identify other potential mechanisms to be used for driving clinical integration	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task 1. Establish provider distribution list (practices).	Completed	1. Establish provider distribution list (practices).	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. Assess MCC's capability to perform clinical integration (CI) needs assessment. If necessary, develop RFP and/or select vendor.	In Progress	2. Assess MCC's capability to perform clinical integration (CI) needs assessment. If necessary, develop RFP and/or select vendor.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Identify validated CI needs assessment tool, such as: a. Clinical Integration Self-Assessment Tool v. 2.0 by Gosfield and Reinertsen b. Physician Alignment and Integration Readiness Assessment by The Chartis Group c. Clinical Integration Readiness Assessment by Dye and Sokolov	In Progress	3. Identify validated CI needs assessment tool, such as: a. Clinical Integration Self-Assessment Tool v. 2.0 by Gosfield and Reinertsen b. Physician Alignment and Integration Readiness Assessment by The Chartis Group c. Clinical Integration Readiness Assessment by Dye and Sokolov	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Present CI needs assessment tool and	In Progress	4. Present CI needs assessment tool and proposed distribution process to the Clinical/Quality Committee for	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
proposed distribution process to the Clinical/Quality Committee for review and approval.		review and approval.							
Task 5. Establish response rate goal.	In Progress	5. Establish response rate goal.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 6. Define distribution process and implementation plan.	In Progress	6. Define distribution process and implementation plan.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 7. Disseminate CI needs assessment.	Not Started	7. Disseminate CI needs assessment.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 8. Gather, aggregate, and analyze responses to identify gaps and CI focus areas.	Not Started	8. Gather, aggregate, and analyze responses to identify gaps and CI focus areas.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 9. Leveraging key data points, identify opportunities for shared access and the key interfaces that will have an impact on clinical integration.	Not Started	9. Leveraging key data points, identify opportunities for shared access and the key interfaces that will have an impact on clinical integration.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 10. Establish CI roll-out strategy informed by the data to support requirements for clinical integration (including clinical providers, care management providers, and other providers impacting on social determinants of health).	Not Started	10. Establish CI roll-out strategy informed by the data to support requirements for clinical integration (including clinical providers, care management providers, and other providers impacting on social determinants of health).	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task	In Progress	1. Develop CI Strategy based on needs assessment and	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
1. Develop CI Strategy based on needs assessment and MCC projects, including protocols, procedures, processes, guidelines that will be used across the projects (e.g., Million Hearts, INTERACT, PAM).		MCC projects, including protocols, procedures, processes, guidelines that will be used across the projects (e.g., Million Hearts, INTERACT, PAM).							
Task 2. Present CI Strategy to the Clinical/Quality Committee for review and approval.	In Progress	2. Present CI Strategy to the Clinical/Quality Committee for review and approval.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 3. Identify all relevant data sources for clinical integration by all PPS members, RHIO, and SHIN-NY, e.g., EHR systems, population health and care coordination modules, data analytic tools.	In Progress	3. Identify all relevant data sources for clinical integration by all PPS members, RHIO, and SHIN-NY, e.g., EHR systems, population health and care coordination modules, data analytic tools.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Catalogue existing programs MCC-wide to leverage best practices and identify gaps.	In Progress	4. Catalogue existing programs MCC-wide to leverage best practices and identify gaps.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 5. In compliance with HIPAA security protocols, develop and test/verify clinical data sharing process for all relevant clinical interfaces (as defined in IT Systems & Processes, milestone #1).	In Progress	5. In compliance with HIPAA security protocols, develop and test/verify clinical data sharing process for all relevant clinical interfaces (as defined in IT Systems & Processes, milestone #1).	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 6. Implement/establish clinical data sharing process.	In Progress	6. Implement/establish clinical data sharing process.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 7. Convene MCC's geographic councils (Niagara Orleans Healthcare Organization, Southern Tier Council) to review and discuss CI plan implementation.	In Progress	7. Convene MCC's geographic councils (Niagara Orleans Healthcare Organization, Southern Tier Council) to review and discuss CI plan implementation.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 8. Roll-out plan to implement a consistent use of efficient and effective evidence-based approaches to care and coordination.	In Progress	8. Roll-out plan to implement a consistent use of efficient and effective evidence-based approaches to care and coordination.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task 9. Implement Care Transitions Strategy developed in 2.a.i. including protocols for hospital	In Progress	9. Implement Care Transitions Strategy developed in 2.a.i. including protocols for hospital admission/discharge coordination, care transitions, and communication among	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
admission/discharge coordination, care transitions, and communication among primary care, mental health, and substance use providers.		primary care, mental health, and substance use providers.							
Task 10. Develop provider-specific/program-specific metrics and reports. Establish transparent program and reporting plan.	Not Started	10. Develop provider-specific/program-specific metrics and reports. Establish transparent program and reporting plan.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task 11. Implement Training/Education Plan outlined in Practitioner Engagement (milestone #2) including providers and operations staff.	Not Started	11. Implement Training/Education Plan outlined in Practitioner Engagement (milestone #2) including providers and operations staff.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 12. Measure and track participation rates.	Not Started	12. Measure and track participation rates.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 13. Measure and report on participation and training topics quarterly to Clinical/Quality Committee.	Not Started	13. Measure and report on participation and training topics quarterly to Clinical/Quality Committee.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

NYS Confidentiality – High

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Milestone Review Status

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

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IPQR Module 9.2 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

Over-reliance on hospital-employed physicians makes it difficult to achieve full CI across the community; they lack the breadth to serve as a foundation for building the clinically integrated, performance-focused platform. Include/engage a cross-section of both independent community-based and hospital-employed physicians in all programming.

Independent (community-based) physicians have limited availability, staff, and financial resources to implement changes in workflow to accommodate new care coordination processes and other DSRIP requirements. Provide centralized support/resources (e.g., physician assistance, care management, PCMH expertise, IT support) for CI efforts.

Stakeholders (e.g. ancillary providers, community-based organizations (CBOs), faith-based organizations, etc.) are too diffuse for organized performance achievements. Develop organized approach for connecting these stakeholders to hospital-based and independent primary care practices (e.g., by leveraging and automating the 211 resource directory). Promote collaboration among these stakeholders via the CBO Task Force. Review progress reports; identify "problem areas" and low-performing organizations for additional support/intervention.

Failure to engage contracted physician groups. Some physician groups may be resistant to the changes proposed. Include contracted physician groups in all clinical implementation strategies. Implement a comprehensive practitioner engagement strategy. Represent a variety of provider types on the Physician Steering Committee to ensure a wide range of voices are heard.

Technology/data integration is not available/ready for deployment in a timely manner. Develop interim technology and data strategies to communicate data to practitioners. For example, leverage existing hospital admission, discharge, and transfer data and push to primary care offices. Work with IT Data Committee on interim steps to integration.

HEALTHeLINK (RHIO) training staff and PPS practice support staff operate independent of each other. Practices receive multiple, uncoordinated, outreach related to practice workflow transformation, causing confusion or distrust. Active, up-front coordination of activities to embed engagement of HEALTHeLINK services into the broader PPS practice transformation service as practices are engaged.

Data is not consistent across practices and EHR vendors. This affects providers trying to interpret Continuity of Care Document data from another practice and impedes the ability to perform analytics across a population whose data is sourced from many practice settings. Practice clinical transformation staff must include EHR data standards implementation in their practice support services integrated with data upload and aggregation capabilities. Implement a data standardization function to validate CCDs from practices at go-live.

EHR vendors may not support interoperability with the RHIO at a reasonable cost, slowing the pace of implementation of interoperability. Have MCC representatives from the IT Data Committee participate in regional, state, and national conversations on this issue; apply pressure to the industry to actively support the free flow of patient data.

Confusion, misinformation, and lack of understanding could cause delays in deployment and integration. MCC will provide detailed education and in-servicing to providers, partners, and their staff about change management, IT security/privacy policies, and other compliance and operational policies and programs.

IPQR Module 9.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

Practitioner engagement: Successful CI implementation is dependent on active practitioner engagement
Population health strategy: CI is a means to population health
IT systems and processes: Data integration and interoperability are essential components of CI
Performance reporting: CI progress is informed by accurate performance reporting
Financial sustainability: CI transformation depends on financial sustainability for such items as interoperability and practitioner incentives
Workforce strategy: CI resources, such as care coordinators, are essential to successful CI implementation
11 projects: An interdependency exists between CI and the MCC clinical projects

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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
Clinical/Quality Committee	Co-chairs: Michael Cummings MD (UBMD Psychiatry); Joanne Haefner FNP (Neighborhood Health Center)	Oversight and approval of Clinical Integration (CI) Strategy and CI Work Plan
IT Data Committee	Gregory Turner, John J. Bono, Anthony Billittier MD, Michele Mercer RN, HEALTHeLINK representatives, Community Partners of WNY (led by Catholic Medical Partners) representatives, Vicki Landes (NFMMC health home), Gail Mayeaux (Universal Primary Care)	Ensure that the IT infrastructure meets the needs of the clinically integrated network
Community-Based Organization (CBO) Task Force	Coordinated by Catherine Lewis, MCC Director of Community-Based Initiatives	Provide advisory feedback on CI Strategy and CI Work Plan
Geographic councils	Niagara Orleans Healthcare Organization (led by Sheila Kee, Niagara Falls Memorial Medical Center) and Southern Tier Council (led by Richard Braun, Olean General Hospital)	Implement CI strategies in the Northern and Southern sub-regions of the PPS; report on progress, challenges, and appropriate solutions
Clinical integration liaisons	Representatives from primary care, specialties, behavioral health, CBOs, care coordination, hospice/palliative care, and population health	Act as liaisons between their respective disciplines and the CI process

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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		
Chief Integration Officer (Michele Mercer RN)	Lead development and implementation of CI Strategy and Work Plan	Develop CI Strategy and Work Plan; present to oversight committees and work groups for feedback and approval; oversee implementation of work plan; report on progress of implementation
Chief Medical Officer (Anthony Billittier MD)	Medical oversight; input into CI Strategy and Work Plan	Work with Chief Clinical Integration Officer to develop CI Strategy and Work Plan; present to oversight committees and work groups for feedback and approval; oversee implementation of Work Plan; report on progress of implementation
Chief Reporting Officer (John J. Bono)	Development of clinical metrics	Develop and implement mutually agreed-upon CI metrics; provide input into measurement criteria and development of reports to the Clinical Quality/Committee, Board of Managers, and NYS DOH.
Representatives from each partner hospital	Buy-in/support of new pathways, lines of accountability, responsibilities, and communications	Engagement in the process, including consultation and training
FQHCs	Buy-in/support of new pathways, lines of accountability, responsibilities, and communications	Engagement in the process, including consultation and training
Behavioral health providers	Buy-in/support of new pathways, lines of accountability, responsibilities, and communications	Engagement in the process, including consultation and training
Health homes	Buy-in/support of new pathways, lines of accountability, responsibilities, and communications	Engagement in the process, including consultation and training
Post-acute providers	Buy-in/support of new pathways, lines of accountability, responsibilities, and communications	Engagement in the process, including consultation and training
Physician networks	Buy-in/support of new pathways, lines of accountability, responsibilities, and communications	Engagement in the process, including consultation and training
MCC Administrative Director (Gregory Turner)	Lead MCC IT strategy; coordinate with lead entity (ECMCC) for IT alignment	Ensure IT solution meets clinical integration and population health business requirements
External Stakeholders		
Departments of Health from each MCC PPS county	Buy-in/support of new pathways, lines of accountability, responsibilities, and communications	Engagement in the process, including consultation and training
Patients	Beneficiary of care improvements driven by CI	Response to consultation on CI Strategy
Family members	Communication with practitioners, particularly on behalf of children, the elderly, or those without mental capacity	Response to consultation on CI Strategy

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Hospice/palliative care providers	Buy-in/support of new pathways, lines of accountability, responsibilities, and communications	Engagement in the process, including consultation and training
CBOs	Buy-in and support of CI Work Plan including new pathways, lines of accountability, responsibility, and communication	Engagement in the process, including consultation and training

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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.

Effective CI will require relevant information to be readily accessible for all providers across the patient care spectrum. For some providers this will mean integration into new or expanded clinical data systems. For other providers in our network, effective CI is likely to rely more heavily on the coordinated use of patient registries and risk stratification. A core element of our CI needs assessment will be identifying where new or expanded data-sharing systems are required and where a different approach is required. The involvement of the IT Data Committee will be important in ensuring that our plans for developing IT infrastructure across the PPS support better CI.

The following areas that will require IT assessment and requirement definition for CI include:
The architecture of the PPS to support a clinically integrated system
The data sharing and confidentiality protocols in place for the PPS
What platforms are being used to support the PPS (EHRs, etc.)
How will the PPS integrate manual processes
Data reporting and performance monitoring
Secure messaging and alerts
Patient and physician portals

Achieving the buy-in from our large community of downstream providers to the new ways of working that fall under the CI workstream will greatly depend on the providers and the individual practitioners having easily accessible methods of communicating with one another.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

Progress reporting will be aligned with the phased approach to implementing the overall CI Strategy, including clinical integration progress within the network. This will be measured by increased adoption of evidence-based clinical pathways by participating PCPs. Clinical integration will also be measured by determining the increased adoption of care coordination within PC practices and across the network. Project success and governance will be measured by the completion of a clinical IT needs assessment, current state assessment of the PPS network, and establishment of a best practice data model flow. Quarterly reports at the project level will include a validated CI needs assessment tool approved by the Clinical/Quality Committee and aggregated analyzed results of the responses to identify gaps and CI focus areas.

Results of the CI needs assessment will be utilized in the development of the CI Strategy. The strategy will include, but not be limited to, the following items:

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Inventory of all data sources
A comprehensive training program
A reporting schedule aligned with finance, governance, cultural competency/health literacy, and performance monitoring

Quarterly project- and unit-level reports will mark progress towards full implementation of the IT infrastructure development plan for interoperability, CI, and population health management.

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

IPQR Module 9.9 - IA Monitoring:

Instructions :

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Section 10 – General Project Reporting

IPQR Module 10.1 - Overall approach to implementation

Instructions :

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

Open, frequent communication is key to successful projects, and MCC is dedicated to a transparent communication process across the PPS. Project activities to improve the healthcare of the targeted population while decreasing overall admission rates will not only affect Medicaid patients attributed to MCC, but the overall health of WNY. As MCC conducts training/education and implements care improvements throughout the community, it will have a secondary effect across all segments of the population. Providers will become more educated in the use of population management metrics and "Plan, Do, Study, Act" (PDSA) cycles, causing a transformation in healthcare. Communication strategies will be critical to all projects, but are particularly important in those that span multiple disciplines or require collaboration among a broad group of stakeholders.

The 11 projects selected by MCC will require major changes—broad, systemic changes at the network level as well as specific alterations in the day-to-day lives of patients and providers. The disruptions caused by these changes, however minute, will be felt throughout the PPS. Eventually, the results (such as improved health outcomes) will stimulate increased patient buy-in and provider involvement. But as these outcomes may take a long time to observe, community-based organizations (CBOs) will be mobilized immediately to help promote the practices and principles of DSRIP. Through community-based organizations the PPS will conduct outreach education, networking, and PCP coordination to ensure patients outside of the PPS will be engaged and linked to a PCP.

The development of a shared IT infrastructure and data sharing ensures the patient information is shared and securely transferred to referring providers and members of the PPS. The ability to share data among care rending groups will enhance the care coordination and decrease risk for the patient for readmission and enhance positive outcomes. Through the IT infrastructure, notifications of care transitional protocols will be established. Data sharing and notifications will support improved care transitions, which are critical to several projects.

MCC, through the Clinical/Quality Committee, will standardize clinical and operational flows to support Patient-Centered Medical Home (PCMH) and patient-focused models. The activities will drive the foundational steps for moving towards a value-based model through improved outcomes. Through PCMH and NYS Advanced Primary Care Model principles the PPS will set standards for identifying high-risk patients, addressing barriers for compliance, and initiating activities to effect change. These activities will be measured and shared across the PPS. PDSA cycles will be initiated to evaluate improvement activities set forth from the practice to meet the quality measures and quickly revise as necessary to continue positive growth.

MCC will work with neighboring PPSs Community Partners of WNY (led by Catholic Medical Partners) and Finger Lakes PPS to create comprehensive healthcare transformations in the region. Close coordination will be assured by encouraging the use of standardized referral protocols, utilizing uniform tracking and reporting systems, adopting universal alert messaging via the RHIO, maintaining common messaging to patients, and sharing lessons learned.

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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.

FINANCIAL

Financial concerns cut across all projects, as practices and facilities are dependent upon financial sustainability. MCC will work with payers to enhance reimbursement strategies to provide sustainability to providers within the PPS. (all projects, Financial Sustainability).

EDUCATION

Education for patients, as well as providers, is key to empowering patients to drive their own healthcare needs as well as instilling confidence in medical staff to utilize new programs/strategies/procedures (2.d.i., Practitioner Engagement, 2.b.iii., 2.b.viii., 3.a.i.)

Gaps in knowledge could hinder outcomes of programs, such as INTERACT (2.b.vii.)

Educating Medicaid beneficiaries on established alternatives to ED will reduce non-emergent ED visits. (2.b.iii., 2.b.vii., 2.b.viii., 3.a.ii.)

Culturally, Linguistically Appropriate Services (CLAS) are very important in patient engagement. (Cultural Competency and Health Literacy, all projects but particularly 2.d.i., 3.b.i., 3.f.i., 4.a.i., 4.d.i.)

STAFFING

This PPS will be seeking highly educated and skilled resources within the PPS area to staff key support roles for all projects and workstreams. (all projects, Workforce Strategy)

The PPS is dependent upon well trained, funded staff availability, and primary physicians trained in areas with current shortages, especially in behavioral health. (2.b.iii., 2.d.i., 3.a.i., 3.b.i., Practitioner Engagement)

PATIENT COORDINATION WITHIN PPS

All providers are highly dependent upon increased levels of communication and coordination for their patients. This is especially challenging due to the current highly fragmented delivery system, the target population's size, and the region's large geographical area. (2.a.i., IT Systems & Processes, Population Health Management)

Connectivity with health home and ACO population management systems will impact ED triage. (2.a.i., 2.b.iii., Population Health Management)
Note: There are no ACOs in WNY participating with MCC.

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Hospitals must help coordinate safe and successful discharges, while passing along all crucial information when patients return to skilled nursing facilities or other facilities. (2.b.iii., 2.b.vii., 2.b.viii.)

Crisis Stabilization is dependent upon ED triage to identify patients who do not need urgent care. (2.b.iii., 3.a.ii.)

IT INFRASTRUCTURE

Connectivity is the backbone for which all providers will be dependent. The ability to safely and easily access patient records is key to improving patient outcomes. (2.a.i., IT Systems & Processes)

All projects are dependent upon the PPS's ability to define data gaps, and implement data quality and content standards at the practice level. This directly impacts the PPS's practice clinical transformation and EHR utilization activities at the practice level. In particular, defining data rules and standards around Continuity of Care Documents (CCDs) as these tend to have a high rate of variability across practices and EHR vendors. This will directly impact the ability to perform population analytics across many practices. (2.a.i., IT Systems & Processes)

Cardiac project is dependent upon project 2.a.i. (Integrated Delivery System) requirement to establish disease registries. (2.a.i., IT Systems & Processes, 3.b.i.)

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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
IT Data Committee	Gregory Turner, John J. Bono, Anthony Billittier MD, Michele Mercer RN, HEALTHeLINK representatives, Community Partners of WNY (led by Catholic Medical Partners) representatives, Vicki Landes (NFMMC health home), Gail Mayeaux (Universal Primary Care)	Technical oversight/direction/coordination [all projects as needed]
MCC Clinical Integration Officer	Michele Mercer RN	Achieve clinical integration through the use of best practices and techniques by healthcare facilities and primary care practices throughout WNY
MCC Director of Community-Based Initiatives	Catherine Lewis	Cultural competency, health literacy, collaboration with CBOs [especially 2.b.iii. (ED Care Triage), 2.d.i. (Patient Activation), 3.a.ii. (Crisis Stabilization), 3.f.i. (Maternal and Child Health), domain 4 projects]
MCC Continuing Education Manager	New hire	Devise strategies to meet training needs through cooperative arrangements with community partners
Project co-sponsor	Community Partners of WNY (led by Catholic Medical Partners)	Provide joint funding; collaborate on standardized cross-PPS protocols and policies; participate in open, frequent communication about project status and objectives [4.a.i. (Promote MEB Well-Being), 3.f.i. (Maternal and Child Health)]
All active project participants (e.g., SNFs implementing INTERACT, individuals being trained on PAM, PCPs offering Million Hearts)	Per project	Meet project requirements according to established timeline, follow any protocols agreed to at PPS level, accept performance-based incentives, use electronic systems to track patients as required [all projects]
MCC Chief Reporting Officer	John J. Bono	Develop and implement plan specifying process and performance metrics to be reported, manner in which data will be reported, designating entities which will receive data, systems for analyzing and responding to data and reporting date to committees and governing board.
MCC Project Management Office	Led by Tammy Fox	Ensure workstreams and projects are coordinated, meet objectives, and contribute to the overall success of the PPS [all projects]

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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		
Home care providers	Participating home health agencies	Provide/promote home healthcare as alternative to hospitalization/SNF admission
CBO Task Force	Coordination of community resources	Coordinate services provided by CBOs to prevent gaps or unnecessary duplication of services
"Voice of the Consumer" Sub-Committee	Patient advocacy and engagement	Obtain direct input from Medicaid recipients
MCC Administrative Director (Gregory Turner)	Reporting oversight	Provide oversight for reporting as it relates to projects
External Stakeholders		
Legislators	Regulatory waivers	Waive regulations that prevent project from achieving objectives
HEALTHeLINK and other RHIOs	HIE	Integration, connectivity, consent [especially project 2.a.i., Integrated Delivery System]
Departments of health from each MCC PPS county (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming)	Region-specific support/services	Assist in implementation of community health improvement strategies, provide region-specific support and services [especially 3.a.i. (Integration of Behavioral Health and Primary Care), 3.a.ii (Crisis Stabilization)]
Health plans and Medicaid managed care organizations	Reimbursement	Provide appropriate reimbursement based on project strategies and objectives, streamline authorization processes to facilitate project success, support value-based payment
Finger Lakes PPS	Coordination	Collaborate on standardized cross-PPS protocols and policies
Community-based and faith-based organizations	Service providers	Provide culturally appropriate services to various populations to support patient engagement/activation and adherence to care plans
Patients, families, caregivers	Care seekers	Care seekers

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IPQR Module 10.5 - IT Requirements

Instructions :

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

MCC is in the process of developing requirements for an Enterprise DSRIP Solution, the technical infrastructure that will support MCC's project and workstream activities. A vendor/partner will be selected via RFP to provide the enabling infrastructure and analytics foundation to pull data and push content and insights across MCC's network.

MCC intends to leverage aggregated patient data available through HEALTHeLINK and augment it with information from other service providers in the PPS such as social service agencies, schools, CBOs, and other providers that do not use electronic patient records. The infrastructure and data foundation provided by HEALTHeLINK will enable the functional capabilities of performance management, decision support, care delivery, care management, population health management, patient engagement, and support services.

The enabling infrastructure which will support implementation of all 11 MCC projects includes the following elements: EMRs, rules engine, network connectivity and security, remote monitoring and mHealth applications, enterprise data warehouse, process automation, reporting tools, portals, advanced analytic tools, and geospatial analysis tools.

A comprehensive service provider network will be created and maintained. The network will be accessible and responsive to identified member needs. This includes use of geospatial mapping to identify "hot spots" and network coverage issues. A provider/network directory will offer a streamlined, electronic means for primary care practices to connect patients to community-based services in their own neighborhoods and communities. This will enable PPS partners to coordinate medical, mental health, and non-medical care efforts (e.g., temporary housing).

A patient registry will be developed which includes patient name, address, CIN number, sex, race, top diagnoses codes, primary care provider of record, payer, risk score, and projects in which they have been engaged. Patient-level clinical data should include additional elements such as BMI, smoking status, cholesterol level, blood sugar level, PAM survey date and score, pregnancy status, most recent encounters, most recent discharge diagnosis, and date of discharge. Registry data will be used to identify care gaps for treatment of identified chronic or acute conditions and for preventative and wellness services.

A Member portal is also envisioned that will enable beneficiaries to look up their own information online and make service requests from their portals. Since most Medicaid members may not have smart phones or computers, MCC seeks to explore the use of secure text messaging to remind members of upcoming appointments or to call their care team for other information or follow up.

Community health workers (CHWs) will perform vital services in connection to several projects (e.g., 3.f.i., Support for Maternal and Child Health). MCC intends to equip CHWs with laptops, tablets, smart phones, or other mobile devices to capture data and share content with Medicaid members. This technology will facilitate easy documentation of home/remote visits, improve communication across the care continuum, provide educational material for members, and keep CHWs in the field connected to the PPS as needed. This will be facilitated through access to a Service Provider portal. MCC will engage with the CBOs to design structured documentation templates that can be accessed in their portal. As the

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CHWs open their template they will query MCC's EMPI solution using name, address and CIN number if known to determine whether the member has an existing EMPI number. The form will automatically be populated with EMPI or a new identifier if the patient is not known. This capability is foundational to creating a 360-degree view of each member.

IPQR Module 10.6 - Performance Monitoring

Instructions :

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

A workgroup composed of members of the Physician Performance Sub-Committee, IT Data Committee, Clinical/Quality Committee, and Finance Committee, with input from the Chief Reporting Officer, Chief Integration Officer, and Finance Director, will develop a performance measurement program, including incentive payment provisions. The workgroup will direct the IT Data Committee in implementation of project-specific performance dashboards. These dashboards will be populated with internal and external data, including the domain 1–4 measures identified in the DSRIP Measure Specification and Reporting Manual and subsequent guidance. The workgroup will develop additional measures and milestones to measure project implementation, quality, and integration and milestones/measures that will be tied to financial incentives.

MCC will establish and identify quality standards using NYS DOH metrics as a starting point. The PPS may add metrics that it deems necessary to successfully meet provider adoption and patient engagement targets for all projects.

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IPQR Module 10.7 - Community Engagement

Instructions :

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

The importance of member involvement in self-care is well documented. MCC will play a vital role in improving health literacy and motivating Medicaid members to improve their overall health and wellness. This includes sharing of appropriate content about their conditions that need to be managed, information about where non-emergent care can be accessed that is closest to them, and how they can be contacted.

MCC will reach out to the public directly by hosting informative events (for example, a wellness expo was hosted in September), appearing regularly in the media (e.g., weekly radio show on WUFO, appearances on television talk shows), implementing publicity/media campaigns, establishing a "Voice of the Consumer" Sub-Committee made up of Medicaid beneficiaries, and appointing a member of this sub-committee as a voting member of the Board of Managers. MCC will these channels to engage the community and to explain DSRIP initiatives to WNY residents.

MCC will also leverage community-based organizations (CBOs) as an indispensable resource for reaching the community at large and specific targeted populations (e.g., refugees). MCC's strategy is to build a broad CBO network that is representative of all of WNY, that will play a vital role in engaging the Medicaid population in the delivery and implementation of DRSIP goals. During the first quarter of 2015, MCC conducted a major outreach campaign to urge CBOs to join the network. MCC directly contacted organizations by telephone and email and encouraged CBO involvement through its website. A total of 280 CBOs were added to the MCC PPS as a result of these outreach efforts. MCC will determine the adequacy of its CBO network as part of the additional community needs assessment work it will conduct to identify health disparities and factors causing poor health outcomes. The plan is to identify additional CBOs which currently exist or which are emerging, particularly in immigrant neighborhoods. As additional CBOs are identified, MCC will enroll them as partners and seek to involve them in PPS work.

In addition to building a broad network of CBOs, MCC will also execute contracts with individual CBOs to provide services related to the projects. Each DSRIP project team is being charged with the responsibility of identifying key CBOs that will assist with project work. A determination will be made as to the number of such CBOs required and the specific services they will perform. MCC will utilize the RFP process as the mechanism for evaluating the capacity of CBOs to provide services. Selection criteria will include experience, references, leadership/administrative capacity, financial viability, cultural and linguistic capabilities, and other characteristics as appropriate.

MCC used this process to select four CBOs to provide patient activation services in connection with the 11th project (2.d.i., Patient Activation). These CBOs, in turn, subcontracted with several additional organizations to reach the patient engagement targets for this project. Dozens of community health workers have been deployed to administer PAM surveys and help connect members with needed services.

MCC is in the process of selecting CBOs to provide services related to Cultural Competency and Health Literacy. CBOs will also be relied upon for projects 3.f.i. (Support for Maternal and Child Health), and 4.d.i. (Reduce Premature Births).

CBOs also provide advice and counsel to MCC's Board of Managers and committees via the CBO Task Force. Over 35 CBO representatives have been appointed to the Task Force, which has been meeting monthly since July. Among other things, the Task Force is responsible for tracking and

monitoring CBO involvement in project work and pinpointing new and evolving opportunities for CBO engagement.

IPQR Module 10.8 - IA Monitoring

Instructions :

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Section 11 – Workforce

IPQR Module 11.1 - Workforce Strategy Spending

Instructions :

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

Funding Type	Year/Quarter										
	DY1(Q1/Q2)($)	DY1(Q3/Q4)($)	DY2(Q1/Q2)($)	DY2(Q3/Q4)($)	DY3(Q1/Q2)($)	DY3(Q3/Q4)($)	DY4(Q1/Q2)($)	DY4(Q3/Q4)($)	DY5(Q1/Q2)($)	DY5(Q3/Q4)($)	Total Spending($)
Retraining	0	0	0	0	0	0	0	0	0	0	0
Redeployment	0	0	0	0	0	0	0	0	0	0	0
Recruitment	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

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IPQR Module 11.2 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Define target workforce state (in line with DSRIP program's goals).	In Progress	Finalized PPS target workforce state, signed off by PPS workforce governance body.	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. Finalize appointments to Workforce Development Work Group and sub-committees; ensure labor representatives, other key stakeholders, and human resources staff from participating facilities are represented. Develop workforce governance decision-making protocols.	Completed	1. Finalize appointments to Workforce Development Work Group and sub-committees; ensure labor representatives, other key stakeholders, and human resources staff from participating facilities are represented. Develop workforce governance decision-making protocols.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task 2. For each specific DSRIP project that has a workforce impact, the Workforce Development Work Group will identify specific workforce requirements using facility surveys and interviews with project managers and key stakeholders.	In Progress	2. For each specific DSRIP project that has a workforce impact, the Workforce Development Work Group will identify specific workforce requirements using facility surveys and interviews with project managers and key stakeholders.	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task 3. The Workforce Development Work Group will perform a project-specific organizational impact assessment using recommended tools to identify level of impact by project, including the anticipated level of impact by role.	In Progress	3. The Workforce Development Work Group will perform a project-specific organizational impact assessment using recommended tools to identify level of impact by project, including the anticipated level of impact by role.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 4. The Workforce Development Work Group will conduct a project-specific analysis that will identify the various levels of workforce resources required to support the DSRIP projects.	In Progress	4. The Workforce Development Work Group will conduct a project-specific analysis that will identify the various levels of workforce resources required to support the DSRIP projects.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task	In Progress	5. The Workforce Development Work Group will aggregate	08/01/2015	12/31/2016	08/01/2015	12/31/2016	12/31/2016	DY2 Q3	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
5. The Workforce Development Work Group will aggregate the project-specific analyses to develop an updated PPS-wide Needs Profile.		the project-specific analyses to develop an updated PPS-wide Needs Profile.							
Task 6. The Workforce Development Work Group will collect and aggregate data into a comprehensive profile of MCC's proposed Target Workforce State.	Not Started	6. The Workforce Development Work Group will collect and aggregate data into a comprehensive profile of MCC's proposed Target Workforce State.	10/01/2015	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 7. The Workforce Development Work Group will define the structure and content of the initial Target Workforce State report as well as quarterly update reports.	Not Started	7. The Workforce Development Work Group will define the structure and content of the initial Target Workforce State report as well as quarterly update reports.	11/01/2015	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 8. The Workforce Development Work Group will finalize the Target Workforce State and submit it to MCC Board of Managers for review and approval.	Not Started	8. The Workforce Development Work Group will finalize the Target Workforce State and submit it to MCC Board of Managers for review and approval.	12/31/2015	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	In Progress	Completed workforce transition roadmap, signed off by PPS workforce governance body.	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. In partnership with MCC leadership and the Workforce Development Work Group, the Workforce Development Director will establish protocols for implementing and monitoring the workforce transition process, including but not limited to procedures for obtaining and allocating resources, providing training, recruiting and redeploying staff, and reporting.	In Progress	1. In partnership with MCC leadership and the Workforce Development Work Group, the Workforce Development Director will establish protocols for implementing and monitoring the workforce transition process, including but not limited to procedures for obtaining and allocating resources, providing training, recruiting and redeploying staff, and reporting.	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 2. The MCC Workforce Development Director will work with the established sub-committees and other key stakeholders to formulate a project-specific timeline for recruitment, redeployment, and retraining.	In Progress	2. The MCC Workforce Development Director will work with the established sub-committees and other key stakeholders to formulate a project-specific timeline for recruitment, redeployment, and retraining.	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 3. The Workforce Development Work Group will	Not Started	3. The Workforce Development Work Group will define the structure and content of the original Workforce Transition	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
define the structure and content of the original Workforce Transition Roadmap and provide subsequent quarterly updates to the roadmap.		Roadmap and provide subsequent quarterly updates to the roadmap.							
Task 4. The Workforce Development Work Group will finalize the Workforce Transition Roadmap and submit it to MCC Board of Managers for review and approval.	Not Started	4. The Workforce Development Work Group will finalize the Workforce Transition Roadmap and submit it to MCC Board of Managers for review and approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	In Progress	Current state assessment report & gap analysis, signed off by PPS workforce governance body.	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO
Task 1. The Workforce Development Director and the Workforce Development Work Group will conduct an assessment of staffing patterns at partner facilities and will analyze certifications, licenses, educational levels, skills, and competencies among a facility's staff through the use of surveys, reports, and interviews.	On Hold	1. The Workforce Development Director and the Workforce Development Work Group will conduct an assessment of staffing patterns at partner facilities and will analyze certifications, licenses, educational levels, skills, and competencies among a facility's staff through the use of surveys, reports, and interviews.	07/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 2. After the current state assessment is complete, the Workforce Development Work Group will compare the Target Workforce State with the current state, identifying specific retraining, redeployment, and new hire needs.	In Progress	2. After the current state assessment is complete, the Workforce Development Work Group will compare the Target Workforce State with the current state, identifying specific retraining, redeployment, and new hire needs.	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task 3. The Workforce Development Work Group will identify resources needed (funding, manpower, methods, metrics, partnerships, etc.) and review projected workforce budget and roadmap for each category of impacted staff.	In Progress	3. The Workforce Development Work Group will identify resources needed (funding, manpower, methods, metrics, partnerships, etc.) and review projected workforce budget and roadmap for each category of impacted staff.	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Define structure and content of report, conduct gap analyses, and submit quarterly updates.	Not Started	4. Define structure and content of report, conduct gap analyses, and submit quarterly updates.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 5. Finalize current state assessment and gap analysis reports and submit them to the Board of	Not Started	5. Finalize current state assessment and gap analysis reports and submit them to the Board of Managers for review and approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Managers for review and approval.									
Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	In Progress	Compensation and benefit analysis report, signed off by PPS workforce governance body.	09/15/2015	07/30/2016	09/15/2015	07/30/2016	09/30/2016	DY2 Q2	YES
Task 1. The Workforce Development Work Group will design content and structure for a survey instrument to collect current compensation information from each participating facility; engage labor representatives and other key stakeholders in the process.	Completed	1. The Workforce Development Work Group will design content and structure for a survey instrument to collect current compensation information from each participating facility; engage labor representatives and other key stakeholders in the process.	09/15/2015	07/30/2016	09/15/2015	12/31/2015	12/31/2015	DY1 Q3	
Task 2. The Workforce Development Work Group will distribute surveys, collect results, conduct follow-up interviews as needed, and compile aggregate current benefit and compensation information from each participating facility.	On Hold	2. The Workforce Development Work Group will distribute surveys, collect results, conduct follow-up interviews as needed, and compile aggregate current benefit and compensation information from each participating facility.	09/15/2015	07/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 3. Using the salary and compensation plan designed in the "Target State" milestone and "Current State" data, the Workforce Development Work Group will analyze and compare data by position, project, roles, employment status (FT, PT) and forecast anticipated impact on targeted employees.	Not Started	3. Using the salary and compensation plan designed in the "Target State" milestone and "Current State" data, the Workforce Development Work Group will analyze and compare data by position, project, roles, employment status (FT, PT) and forecast anticipated impact on targeted employees.	03/01/2016	07/30/2016	03/01/2016	07/30/2016	09/30/2016	DY2 Q2	
Task 4. Conduct meetings with HR, labor representatives, and key stakeholders to develop and implement policies which affect staff who may be impacted by redeployment or retraining.	Not Started	4. Conduct meetings with HR, labor representatives, and key stakeholders to develop and implement policies which affect staff who may be impacted by redeployment or retraining.	03/01/2016	07/30/2016	03/01/2016	07/30/2016	09/30/2016	DY2 Q2	
Task 5. Finalize Compensation and Benefit Analysis Report and submit to the Board of Managers for review and approval.	Not Started	5. Finalize Compensation and Benefit Analysis Report and submit to the Board of Managers for review and approval.	01/01/2016	07/30/2016	01/01/2016	07/30/2016	09/30/2016	DY2 Q2	
Milestone #5	In Progress	Finalized training strategy, signed off by PPS workforce	07/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	NO

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Develop training strategy.		governance body.							
Task 1. The Workforce Development Director will work closely with HR staff at participating facilities to conduct a comprehensive customized training needs assessment for targeted staff.	On Hold	1. The Workforce Development Director will work closely with HR staff at participating facilities to conduct a comprehensive customized training needs assessment for targeted staff.	09/01/2015	12/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task 2. Compile a comprehensive project and individual training needs list, including specific skills and certifications required.	Not Started	2. Compile a comprehensive project and individual training needs list, including specific skills and certifications required.	07/01/2015	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task 3. The Workforce Development Work Group will establish procedures for implementing and monitoring the Workforce Training Strategy, including but not limited to describing procedures for obtaining and allocating resources, providing training, and implementing reporting requirements.	Not Started	3. The Workforce Development Work Group will establish procedures for implementing and monitoring the Workforce Training Strategy, including but not limited to describing procedures for obtaining and allocating resources, providing training, and implementing reporting requirements.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 4. Evaluations will be distributed to participants for feedback on classes/course at time of participation. Revisions to classes/courses will be made based on participant feedback. Rural AHEC will follow-up with participants three months after educational event to evaluate effect of classes on employment situation.	Not Started	4. Evaluations will be distributed to participants for feedback on classes/course at time of participation. Revisions to classes/courses will be made based on participant feedback. Rural AHEC will follow-up with participants three months after educational event to evaluate effect of classes on employment situation.	10/01/2015	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task 5. The Workforce Development Work Group will finalize the Workforce Training Strategy and submit it to the Board of Managers for review and approval.	Not Started	5. The Workforce Development Work Group will finalize the Workforce Training Strategy and submit it to the Board of Managers for review and approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

NYS Confidentiality – High

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Define target workforce state (in line with DSRIP program's goals).	Working with workgroup and project managers to complete task #2; contacting agencies to set up appointments for task #3. Still gathering information for tasks #4-5.
Create a workforce transition roadmap for achieving defined target workforce state.	Work is ongoing with subcommittees to complete task #2.
Perform detailed gap analysis between current state assessment of workforce and projected future state.	It took longer than expected to get surveys from facilities for task #2. Meeting with key stakeholders to discuss needs related to task #3. Task #1 was put on hold as information was being collected and aggregated.
Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	
Develop training strategy.	Task #1 was put on hold as the current workforce survey rolled out. We began the task by talking with project managers. Interviews with agencies will begin in Q4. Activities have centered around identifying training sites and training programs as well as institutions and CBOs that provide those trainings.

Milestone Review Status

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

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IPQR Module 11.3 - PPS Defined Milestones

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

MCC may have difficulty recruiting sufficient numbers of staff needed. This will be an issue with lower-paying community-based positions (e.g., CHWs) and positions where a high level of education/certification/licensure is required (e.g. Licensed Clinical Social Worker). This is especially problematic since two other PPSs in WNY will be competing for the same resources. Determine appropriate incentives and promote career ladder pathways. Work with local colleges, universities, and other educational resources to build a pipeline of qualified workers. Establish retraining programs to facilitate redeployment. Consider retention bonuses for lower-paying positions. Work with other PPSs to host joint job fairs and training/retraining sessions.

Resistance to change: staff, labor representatives, workforce, and key stakeholders will resist the workforce changes needed for success. Engage all participants throughout the process through assessment, communication, and training. These efforts will promote openness and transparency and involve affected members in the decision-making process.

Managing the differences in HR policies between facilities could become a barrier to inter-PPS movement. Employees moved between organizations, even affiliated organizations, could have different in-house HR services available to support the changes. The Workforce Development Work Group, with support from the workforce vendor and in close collaboration with facility HR departments, will provide clear and consistent protocols to support the changes and address challenges across the PPS. The Work Group will facilitate the establishment of protocols for implementing and monitoring the workforce transition process.

Lack of compatible technological infrastructure for data sharing, reporting, and communication, as well as a lack of appropriately trained staff. MCC will use a phased approach to project rollout, IT development, and reporting. Early reliance on free, open source solutions for data collection and analysis provides a "fallback" option for maintaining continuity of operations. MCC will grow our internal capacities and help direct the development of IT resources across the region. Appropriate training will be offered to staff members.

Negative ramifications for employees who refuse retraining/redeployment. A segment of the employee population will find the changes untenable. In facilities that are unionized, employees may seek to avoid the changes through grievances and refusal to cooperate. The PPS will refer employees to their HR department and/or union pursuant to existing agreements. The PPS will also engage the workforce vendor to provide input into the process of addressing staffing gaps and addressing retraining/redeployment refusals. Disciplinary action will be considered only as a last resort.

Funding received is insufficient to achieve the PPS' stated achievement goals. All projects will utilize flexible, phased project plans that can be adjusted as needed. MCC will engage no-cost training provided by community experts and will share project resources when applicable (e.g., INTERACT coaches for both 2bvii and 2bviii). MCC will also work towards value-based payment reform in order to control costs and ensure sustainability.

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IPQR Module 11.5 - Major Dependencies on Organizational Workstreams

Instructions :

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

The workforce implementation plan is interrelated with every workstream and every DSRIP project. As a general overarching reality, without an effective, comprehensive workforce strategy, no workstream can be successful.

The IT Systems and Processes workstream is dependent upon an effective workforce strategy to recruit staff to build and manage systems, and to train IT staff on effective use of varied software.

Cultural Competency and Health Literacy need to be integrated into each aspect of the workforce strategy. Whether staff are retained, hired, retrained, or redeployed, it will be necessary for the workforce to be culturally competent.

Financial Sustainability: Adequate resources are key to successful transformation. Funds need to be available to support all aspects of the recruitment, training, and redeployment processes. In addition, financial delays could be detrimental to small partners attempting to participate in workforce transformation if resources are unavailable to provide needed training programs and develop required career and academic pathways.

Governance and Performance Reporting are also critical to the success of the transformation. Each participating partner needs to fully understand and participate in the process. Success is dependent upon active participation and engagement, including responding to required data needs for reporting.

Clinical Integration is dependent upon a successful transformation of the workforce. Training programs and new operational procedures will have a significant impact on successful integration into the care process.

In addition, Practitioner Engagement, through effective integration of communication processes as outlined in the Practitioner Communication and Engagement Plan, is critical for success. Continued transformation of the workforce and the care process requires active participation.

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IPQR Module 11.6 - Roles and Responsibilities

Instructions :

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

Role	Name of person / organization (if known at this stage)	Key deliverables / responsibilities
MCC Workforce Development Director	Juan Santiago	Oversee, develop, and implement workforce transformation plans; oversee development of job descriptions, workflow procedures, and recruitment; provide information and assure continuous communication among employees, labor reps, community-based organizations (CBOs), and MCC
Workforce vendor	Western New York Rural Area Health Education Center (R-AHEC)	Sub-contract with MCC for a variety of services including, but not limited to, co-chairing the Workforce Work Group, identifying local and regional training providers, assessing and delivering various trainings, assessing current healthcare workforce needs, providing job coaching and case management for workforce program participants, and acting as a data warehouse for training information and workforce survey information
Workforce Development Work Group (members will be added or removed as needed)	Co-Chairs: Valerie Putney (R-AHEC), Juan Santiago (MCC) Members: Bono, Jamie (MCC); Bright, Carolyn (NYSDOL); Canazzi, Richard (AFSCME); Craig, Mary (ENAHEC); Culkin-Jacobia, Julia (ECMCC); DiCanio-Clarke, Carla (ECMCC); Donahue, Laura (Kaleida); Freer, Tim (NFMMC); Graham, Michael (NYSNA); Hammonds, Al (MCC); Hayes, Debra (CWA); Huff, Cathy (R-AHEC); Kemblowski, Siobhain (SEIU 1199); Kemp, Christine (SNAPCAP); McNamara, Tim (UAHS); Mendola, Isabella (CSEA); Prete, Dave (R-AHEC); Scordato, Jim (SEIU 1199); Sull, Nathan (NYSNA); Swartz, Karen (Kaleida); Szymura, Denise (CSEA); Turner, Greg (MCC); Wilkinson, Bill (CSEA)	Facilitate employee data collection; monitor and report to Board of Managers; assist in development of job descriptions, workflow procedures, and recruitment; promote and manage communication among employees, labor reps, CBOs, and MCC
Current Workforce/Compensation/ Benefit Survey (a sub-committee of the Workforce Development Work Group)	Juan Santiago (ECMCC/MCC), Valerie Putney (R-AHEC), Julia Calkin-Jacobia (ECMCC), Bella Mendolla (CSEA)	Conduct Current Workforce/Compensation/Benefit Survey
Future State Workforce (a sub-committee of the Workforce Development Work Group)	Siobhain Kemblowski (SEIU 1199), Laura Donahue (Kaleida), Debbie Hayes (CWA), Juan Santiago (ECMCC/MCC), Valerie Putney (R-AHEC)	Determine Future State Workforce
Practitioner Engagement Coordinator	Jillian Barone	Help coordinate training for providers; identify appropriate training offerings and incentives; collaborate on communication to providers

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IPQR Module 11.7 - Key Stakeholders

Instructions :

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

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Internal Stakeholders		
Training departments/programs within PPS partner organizations	Training providers/partners	Coordinate to deliver needed training to partner staff
MCC project managers	Project managers	Identify training needs specific to projects and workstreams; coordinate with Workforce Development Director to ensure training fills these needs
Chief Medical Officer	Supervision/oversight	Coordinate with other practitioner engagement and communication activities
External Stakeholders		
Buffalo Niagara HR Associates	Professional association	Support HR activities and leadership
Training agencies	Training provider	Offer variety of training programs
1199 SEIU, NYSNA, AFSCME, CSEA, CWA, and others as identified	Labor representatives	Provide communication among employees and workforce team; provide expertise and insight into effective processes
PX 21 Coalition, Buffalo	Coalition of substance abuse/mental health agencies	Provide training (via training committee)
Community Health Workers of Buffalo, Jessica Bauer Walker, Executive Director	Training	Provide CHW training with emphasis on health education and promotion, community building, and advocacy; offer CHW certificate in partnership with Canisius
R-AHEC, Cathy Huff, CEO	Training	Provide training in rural areas
Staff education departments; nursing in-service education departments	Education	Provide clinical/nursing education; educate staff for DSRIP protocols
Colleges and universities with certificate/education programs (e.g., D'Youville, Daemen, UB, NU, Medaille, ECC, NCCC, Trocaire, BOCES, Harkness)	Education	Provide workforce education for DSRIP protocols
UB School of Social Work; Office of Continuing Education	Training and certification/credentialing support	Support DSRIP policy and procedures
Millard Fillmore College	Adult education on practice transformation	Offer certificate program (practice transformation based on AHRQ curriculum)
Empire State College; Jewish Community Center of Greater Buffalo	Adult education	Offer adult education classes

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Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Infant community programs (e.g., Healthy Babies, Maternal and Infant Community Health Collaborative---MICHC)	Program-specific training programs	Provide training/orientation related to specific programs
Vocational and Educational Services for Individuals with Disabilities (VESID)	Training	Provide education opportunities to disabled individuals
Other PPSs	Networking; collaboration	Collaborate with other PPSs in developing ideas, sharing, networking, and learning across the state

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IPQR Module 11.8 - IT Expectations

Instructions :

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

Data around workforce transformation will be collected, analyzed, and reported upon in order to determine the success and progress of the workforce development efforts. Appropriate data controls, collection, and analytical platforms will be needed to support these efforts. Dashboard or report card capabilities will help PPS partners understand current status/progress and highlight issues that need attention. IT support is also required to facilitate required data collection/reporting/export. It will also be important to track staff movement and changes across the PPS. A learning management system may be required to coordinate and record training/educational efforts.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

Progress reporting will be aligned with the phased approach to implementing the overall Workforce Strategy. As the Workforce Strategy is developed and refined, quarterly project and unit level progress reports will include:

A list of Workforce Development Work Group members and key stakeholders

A regular meeting schedule and meeting minutes

A documented assessment of project workforce needs and Target Workforce State

A Workforce Transition Roadmap, submitted to and approved by the Board of Managers

A documented Compensation and Benefit Analysis Report

Comprehensive Training Strategy

A reporting schedule aligned with finance, governance, cultural competency/health literacy, and performance monitoring

Quarterly reports help partners to gain meaningful status on their own progress towards goals. Overall project and workstream success will be reported to partners and NYS DOH. Reports will include analyses of, but not be limited to, the following:

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Number of people retrained, redeployed, and hired

Training programs/sessions conducted

Breakdown of full (95–100% of previous compensation) vs. partial (less than 95%) placement

Breakdown of new hires by staff type

Summary of compensation/benefit impacts

Specifically, we will report progress of the workforce strategy on three levels. First, working collaboratively with partnering facilities who will identify employees affected by the DSRIP project, we will be able to ensure that the proper people receive the proper training and that both employee and facility profit from the educational endeavor. For example, the INTERACT program will be rolled out to care staff at participating SNFs. A trained staff will reduce the number of acute care transfers; therefore benefiting facility, employee, and patient.

Secondly, we will evaluate progress on the percentage of workforce need that has been met. We will do that by surveying partnering facilities and reevaluating what positions have been filled and where the greatest demand/vacancies lie. After which we will change our approach to recruitment and training if needed.

Finally, we will conduct a quantitative evaluation assessing the success of each project based on collected numbers of consumers reached and reduction of ED visits.

MCC will utilize a central data warehouse and document archive to manage and track project and workstream requirements across the organization, including internal and external milestones, policies and procedures, and other key documents. This central repository will form the basis of our overall project tracking and reporting infrastructure and will allow users to access information appropriate to their role within the organization. Such a system will support project and program management by being a source for regularly scheduled reports and searchable information as dictated by project and program management requirements. This data source will be maintained as part of the PPS's critical operational infrastructure and will enable auditing, version control, and other project tracking functions across the organization.

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IPQR Module 11.10 - Staff Impact

Instructions :

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

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

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

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

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

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IPQR Module 11.11 - IA Monitoring:

Instructions :

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

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

Instructions :

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

Data is not consistent across practices and EHR vendors. This affects providers trying to interpret Continuity of Care Document (CCD) data from another practice and impedes the ability to perform analytics across a population whose data is sourced from many practice settings. Practice clinical transformation staff must include EHR data standards implementation in their practice support services integrated with data upload and aggregation capabilities. Implement a data standardization function to validate CCDs from practices at go-live (this could be done at the RHIO level). Feedback to practice clinical transformation staff for intervention.

EHR vendors may not support interoperability with the RHIO at a reasonable cost, slowing the pace of implementation of interoperability. Have MCC representatives from the IT Data Committee participate in regional, state, and national conversations on this issue; apply pressure to the industry to actively support the free flow of patient data.

HEALTHeLINK (RHIO) training staff and PPS practice support staff operate independent of each other. Practices receive multiple, uncoordinated, outreach related to practice workflow transformation, causing confusion or distrust. Active, up-front coordination of activities to embed engagement of HEALTHeLINK services into the broader PPS practice transformation service as practices are engaged. Include HEALTHeLINK as part of the broader PPS activities.

Current fragmentation of services delivered in the market and wide geographic distribution of the PPS pose a risk to successful and timely development of an IDS. Clearly define goals and requirements up front, have a strong Program Management Office (PMO) and a timely and clearly defined communication plan to address at-risk activities.

The PPS's extensive and diverse membership cannot agree to appropriate IT security controls required for data exchange. A lack of confidence in the MCC PPS could cause providers and organizations to exit the PPS or not become fully committed. Establish openness, direct engagement, and strong communications between MCC and its partners' representatives. Initiate Active Monitoring of systems and make reports available to all PPS members.

Enterprise DSRIP solution cannot be completed until gap analysis concerning data capabilities and connectivity requirements is completed. Likewise, required security controls cannot be designed until the state of security is accessed via the gap analysis. Any delay will cause a cascade effect. Develop a strong PMO; clearly define goals and requirements; provide regular reports to MCC governance.

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Create list of participating providers across the network.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Perform initial gap assessment to identify any gaps in the PPS network, particularly among community-based organizations (CBOs), pharmacists, dentists, behavioral health providers, and key primary care providers (PCPs). Utilize the Community Needs Assessment to identify key areas of focus.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Identify additional gaps by gathering information and recommendations from existing partners/members, the CBO Task Force, the "Voice of the Consumer" Sub-Committee, and geographic councils.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Issue requests for proposals (RFPs) for services to be performed by CBOs, including (but not limited to) cultural competency and health literacy training, Patient Activation coaching, and other services in connection with specific DSRIP projects (see Governance milestone #6).	Project		Completed	04/01/2015	10/03/2015	04/01/2015	10/03/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 5. Implement a strategy to maximize participation of all PPS partners in MCC projects and activities, provide frequent communication and education through a variety of channels including (but not limited to) biweekly newsletters emailed directly to participating providers and regular updates to the website. Conduct quarterly touchpoints to connect partners to projects and educate them on techniques for referring patients to other MCC partners.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. As part of governance structure, establish a process to conduct periodic (quarterly) assessments of provider network in geographic areas throughout WNY to ensure that Medicaid beneficiaries have access to service providers.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Perform gap analysis of PPS providers' capabilities for EHR and data exchange (possess full EHR system, possess some EHR capabilities, or no EHR capabilities).	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8. Develop comprehensive PPS partner database to house all data for readiness, implementation, and ongoing reporting. Partner database will have the capability to produce the provider network list and demonstrate changes to the network list.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task 9. Develop ongoing review procedures to ensure that network partners have completed the necessary privacy and participation agreements to serve as a provider in the MCC network. Establish contractual agreements with partners.	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10. Use these gaps, along with results of the Clinical Integration Needs Assessment, to develop a high-level roadmap for inclusion and integration of all partner organizations in the integrated delivery system (IDS).	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 11. Engage with local RHIO to develop increased EMR capacity.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 12. Work with HEALTHeLINK to deploy data exchange alerts and messaging environment.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 13. Establish and maintain working relationships with payers to engage them to support IDS strategy.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 14. Identify payers and ancillary social service organization connectivity requirements; build data interfaces for these entities (if applicable).	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 15. Establish reports and secure dashboards so providers and stakeholders can monitor success and quality of data exchange and integration and make recommendations to the MCC IT Data Committee and individual providers to improve data exchange and integration.	Project		In Progress	01/01/2016	12/31/2016	11/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 16. IT Data Committee monitors reports and dashboards to identify trends and makes recommendations for improved data access, exchange, integration, and use. Recommendations are reported to the Board of Managers.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
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	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	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	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Produce and maintain list of the major health home (HH) organizations in WNY (five organizations). (There are no ACOs in WNY participating with MCC.)	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Finalize and maintain written agreements with protocols for coordinating care.	Project		In Progress	07/27/2015	09/30/2016	07/27/2015	09/30/2016	09/30/2016	DY2 Q2
Task	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
3. Assess HH population health management systems and capabilities. Implement evidence-based models to establish linkages with HH population health and care management services. Create system for informing PPS partners of availability of these services.									
Task 4. Meet regularly with leadership from HHs to continue to refine collaborative care practices and integrated service delivery. Discuss how and the extent to which their care management services are connected to EDs, hospital discharge planning, behavioral health, home care services, and safety net PCPs and develop care management linkage recommendations. Maintain evidence of interaction.	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Conduct gap analysis to identify gaps in HH members' data exchange and data access capabilities. Verify MCC IDS and EHR solution appropriately addresses these outliers, safety net organizations, behavioral health providers, and patient support members.	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 6. Begin providing periodic progress reports to demonstrate service integration; incorporate a population management strategy towards evolving into an IDS.	Project		Not Started	01/01/2016	03/31/2017	03/01/2016	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task PPS trains staff on IDS protocols and processes.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Recruit and appoint qualified individual to oversee care management across PPS, enable development and dissemination of consistent information/processes, manage care management process, and promote integration and coordination among entities delivering care management.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Develop Care Transitions Strategy, as required in Clinical Integration, including process flow changes required to successfully implement IDS. Develop process flow diagrams demonstrating IDS processes. Leverage Community Health Workers (defined in detail in projects 2.b.iii. ED Care Triage, 2.b.vii. INTERACT, and 2.b.viii. Hospital/Home Care).	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Work with project directors, Workforce Development Work Group, and others to determine the knowledge, competencies, and licensures required for care management to effectively work with patients to ensure they receive appropriate healthcare and community support.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Using CNA and other inputs, finalize inventory of WNY agencies providing care management services, including HHs, WNY Care Management Coalition, etc. Identify PPS partners and hospitals that must be linked for effective transitions of care.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 5. Define care management continuum. For each role along the care continuum, describe criteria for patient referral, workflows, care planning process, responsibilities associated with transitions of care, policies and procedures, outcome measure reporting techniques, etc.	Project		In Progress	07/27/2015	03/31/2016	07/27/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6. Identify cultural and language issues that must be addressed in care management, linkages with medical home care management services, and system for informing PPS partners of availability of chronic disease self-management services.	Project		In Progress	07/27/2015	03/31/2016	07/27/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7. Convene three sub-regional meetings of individuals with	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
knowledge of hospital-to-home transitions, hospital-to-nursing home transitions, and nursing home-to-skilled nursing facility (SNF) transitions to assess current practices, identify data needs, review root cause analyses, and develop standards for maximizing effectiveness of transitions of care across the PPS. Maintain records including meeting schedules, agendas, minutes, and lists of attendees.									
Task 8. Finalize protocols for warm hand-offs of patients from intensive 30-day post-discharge care planning to HH care management services.	Project		In Progress	07/27/2015	09/30/2016	07/27/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9. Engage trainers to provide introductory and ongoing care management training on policies and procedures to care managers. Provide written training materials, list of training dates, and number of staff trained.	Project		In Progress	07/27/2015	09/30/2016	07/27/2015	09/30/2016	09/30/2016	DY2 Q2
Task 10. Develop standards for utilizing existing EHR systems to capture key data and process measures related to DSRIP goals for reporting on care management.	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 11. Implement process for tracking care outside of hospital to ensure that all critical follow-up services and appointment reminders are followed. Process will include contract, report, periodic reporting of discharge plans uploaded into EHR, and other means of demonstrating implementation of the system.	Project		In Progress	07/27/2015	03/31/2017	07/27/2015	03/31/2017	03/31/2017	DY2 Q4
Task 12. In concert with IT, develop short- and mid-term IT platforms to use for tracking, monitoring, and reporting on care coordination transition processes and outcomes to ensure interoperability for all participating providers. Leverage existing PPS data exchange capabilities; reduce data redundancies.	Project		In Progress	07/27/2015	03/31/2017	07/27/2015	03/31/2017	03/31/2017	DY2 Q4
Task 13. Work with payers and others to clarify and develop care coordination and transition management billing processes; provide such information to providers.	Project		In Progress	07/27/2015	03/31/2017	07/27/2015	03/31/2017	03/31/2017	DY2 Q4
Task 14. Using evidence-based models, develop a plan to establish a	Project		In Progress	07/27/2015	03/31/2017	07/27/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
chronic disease self-management program for use by providers throughout the PPS. Include catalog of existing chronic disease self-management providers. Collaborate with existing chronic disease self-management providers (CDSMP) to identify program offerings.									
Task 15. Clinical/Quality Committee, PSC, and Physician Performance Sub-Committee will monitor reports and dashboards to identify trends and make recommendations for improved data access, exchange, integration, and use.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information 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	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Conduct gap analysis to determine which providers have already completed PCMH/MU or other connectivity readiness assessment.	Project		In Progress	05/11/2015	06/30/2016	05/11/2015	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
- Is the practice/providers/patients currently connected to the HIE? - If not, is an agreement in place? - If so, what is the scope of the connectivity (% of providers; % of patients)? - Does EHR meet connectivity requirements of RHIO/SHIN-NY? - Name of EHR, version, and electronic functionalities in use									
Task 2. Develop strategy for low-cost data connectivity between Internet Service Providers (ISPs) (e.g., WNY R-AHEC) and local practice plans to determine minimum hardware and software requirements.	Project		In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Gather results from readiness assessments already conducted.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Issue request for applications (RFA) or other action step for readiness assessment and transformation support services.	Project		In Progress	06/01/2015	06/30/2016	06/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Select vendor or implement other structure for readiness assessment and transformation support services.	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 6. Identify funding model and/or PPS provider incentive model for EHR with the Finance Committee.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Connect PPS providers to enterprise DSRIP solution.	Project		Not Started	06/30/2016	06/30/2017	06/30/2016	06/30/2017	06/30/2017	DY3 Q1
Task 8. Systematically contact PPS providers to provide the recommended enterprise DSRIP solution.	Project		Not Started	01/01/2016	06/30/2017	01/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 9. Facilitate QE participation agreements with MCC providers.	Project		Not Started	06/30/2016	09/30/2017	06/30/2016	09/30/2017	09/30/2017	DY3 Q2
Task 10. Develop and implement training on use of enterprise DSRIP solution, including development of written materials. Track training dates and number of staff trained.	Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 11. Implement and deploy alerts. Provide EHR vendor documentation, screenshots, and/or evidence of use of alerts.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3

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12. Implement and deploy secure Direct messaging. Provide EHR vendor documentation, screenshots, and/or evidence of use of secure Direct messaging.									
Task 13. Implement and deploy patient record look-up. Provide EHR vendor documentation, screenshots, and/or evidence of use of patient record look-up.	Project		In Progress	04/01/2015	12/31/2017	04/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 14. Implement and deploy public health reporting capabilities. Provide EHR vendor documentation, screenshots, and/or samples of transactions to public health registries.	Project		Not Started	06/01/2016	12/31/2017	06/01/2016	12/31/2017	12/31/2017	DY3 Q3
Task 15. Continuously add PPS members when their EHR and data exchange capabilities reach the minimal level required to connect to the enterprise DSRIP solution.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 16. PPS providers who are not actively exchanging systems will be addressed by the Physician Performance Sub-Committee. Corrective actions will be implemented for those PPS members found noncompliant.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Conduct Safety Net MU stage 2 CMS/PCMH level 3 readiness assessment: a. Identify site-specific IT/care management leadership b. Determine current EHR PCMH/MU certification status c. Identify site-specific barriers and risks to implementing a MU/PCMH Level 3 certified EHR system	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2

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Task 2. Facilitate engagement with MU/PCMH-certified EHR vendors as needed.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Establish PCMH/MU project implementation plan based on primary care practice readiness and certification status.	Project		In Progress	07/27/2015	03/31/2017	07/27/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Review PCMH implementation plan for approval by the Clinical Quality Committee	Project		Completed	01/01/2016	03/31/2017	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Ensure practices have support through the PCMH implementation process either through a vendor or through MCC PCMH coordinators.	Project		Not Started	03/01/2016	06/30/2017	03/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 6. Establish a monthly review and measurement process of implementation progress and report to Clinical/Quality Committee.	Project		Not Started	02/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 7. Modify implementation plan as needed based on monthly review process.	Project		Not Started	02/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.	Project		In Progress	07/27/2015	03/31/2018	07/27/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Define IT requirements for initializing/maintaining/communicating risk stratification across settings, including means for electronic interfacing to the participating provider community and key data sharing.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Implement and deploy population health management risk stratification models and data analytics system leveraging data	Project		In Progress	09/01/2015	09/30/2016	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
from the MCC integrated EHR and data exchange/HIE environments.									
Task 3. Identify gaps in care based on established clinical practice guidelines.	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 4. Define priority target population, pilot test, and implement risk-stratified patient registries (high risk, moderate risk, low risk, and well).	Project		In Progress	09/01/2015	12/31/2016	09/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Track and monitor registry results and reductions in gaps in care to verify continuous improvement.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Establish the capabilities to report on patient engagement according to project reporting requirements.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	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	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Perform PCMH and MU readiness assessment and transformation support services for primary care practices: a. Issue RFA or other action step for readiness assessment and transformation support services; b. Select vendor(s).	Project		In Progress	07/27/2015	09/30/2016	07/27/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Identify site-specific physician champions and site-specific IT/care management leadership. Determine PCMH/MU current	Project		In Progress	07/27/2015	09/30/2016	07/27/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
status and identify site-specific barriers and risks to transformation.									
Task 3. Gather results from readiness assessments already conducted.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Based on CNA results and current data, identify primary care shortages in high-need areas.	Project		In Progress	04/01/2015	12/31/2016	04/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Complete gap analysis for all MU/PCMH level 3 elements based on readiness assessment results.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 6. Each site will change policy/procedures, roles/responsibilities, workflow for population health management/care management/care coordination during transitions, performance measurement, CAHPS measurement as needed to meet PCMH/MU standards.	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 7. Implement strategies to recruit PCPs to serve high-need areas. Provide status reporting of recruitment of PCPs, particularly in high-need areas, and monitor improvements in access via CAHPS measurement.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.	Project		In Progress	07/27/2015	03/31/2018	07/27/2015	03/31/2018	03/31/2018	DY3 Q4
Task 9. Maintain list of current/updated NCQA certified practices and EHR MU certifications.	Project		In Progress	07/27/2015	03/31/2018	07/27/2015	03/31/2018	03/31/2018	DY3 Q4
Task 10. Initiate PPS monitoring, oversight, and corrective action: a. PSC and Physician Performance Sub-Committee monitor reports and dashboards to identify trends in adherence to MU and PCMH level 3 standards b. Results will drive recommendations to improve meeting MU and PCMH measures c. Non-responsive PCPs will be addressed by the Physician Performance Sub-Committee with corrective action	Project		Not Started	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Contract with Medicaid Managed Care Organizations and other	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Assess ability for MCC to contract as IDS with MCOs.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Elicit input from MCOs on elements of a multi-year plan to transition to VBP system; present MCC's proposed multi-year plan to MCOs.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Depending on MCO cooperation, establish work plan that addresses establishing VBP arrangements, and goals to accomplish milestone 8.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Seek and obtain MCOs' revisions to plan. Secure MCOs' approval of plan. Catalog main issues/data needs that require resolution as part of the plan approval process.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Establish partner-specific incentives based on established utilization and quality metrics.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 6. Utilize approved value-based payment (VBP) transition plan to guide agenda-setting in monthly meetings with MCOs.	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 7. Provide documentation of executed Medicaid Managed Care contracts.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Set up system to monitor progress with respect to evaluating the VBP transition plan's guideposts against actual results. Provide reports demonstrating percentage of total provider Medicaid reimbursement using value-based payments.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. MCOs make recommendations to MCC on VBP arrangements. Implement programs, in-servicing information, and proposals for MCC partners based on MCO recommendations via the Physician Steering Committee.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #9	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Establish VBP Sub-Committee to include representation from behavioral health, adult- and child-care providers, and peers.	Project		In Progress	07/27/2015	01/01/2016	07/27/2015	01/01/2016	03/31/2016	DY1 Q4
Task 2. Charge VBP Sub-Committee (see Milestone #10) with responsibility of recommending structure and process to meet regularly with MCOs to review and evaluate costs, quality, utilization, and other relevant topics.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. For each of the top four MCOs serving WNY (Independent Health, Fidelis, Blue Cross Blue Shield, and YourCare) define the following: participants, meeting schedule, agenda items, and other relevant processes for building PPS partnerships. Establish a process of reporting meeting outcomes/recommendations to stakeholders and PPS leadership. Maintain records of meeting agendas, attendees, minutes, and materials.	Project		In Progress	05/01/2015	03/31/2016	05/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Ascertain from NYS DOH what recourses are available to PPS if an MCO does not agree to meet regularly or to engage in an organized VBP agenda with PPS.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5. Devise and secure buy-in from MCOs that they will adhere to a timetable for transitioning to a VBP system.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6. Establish agreed-upon data sources, utilization and performance metrics, reports, and dashboard.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 7. Report Medicaid managed care metrics and opportunities to MCC Board of Manager committees.	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 8. Publish dashboards to MCC intranet for transparency with partners.	Project		In Progress	03/31/2016	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Task 9. Identify opportunities for improvement based on the agreed-upon metrics and reports and develop process improvement strategies.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Measure and report progress of process improvement plans to MCC governance on a quarterly basis.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Establish VBP Sub-Committee under MCC's Finance Committee with representatives from finance, legal, medical staff, executive leadership, and others, to formulate a multi-year VBP transition plan.	Project		In Progress	07/27/2015	01/01/2016	07/27/2015	01/30/2016	03/31/2016	DY1 Q4
Task 2. Engage external expert/consultant to assist in and provide recommendations for development of five-year plan for transitioning to value-based reform system.	Project		Completed	07/27/2015	12/31/2015	07/27/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. As part of plan, summarize process measures and clinical outcome benchmarks that will guide PPS's work over five years.	Project		In Progress	07/27/2015	06/30/2016	07/27/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Based on data from population health, data analytics, PAM, coordination of care, HEDIS, predictive monitoring, risk stratification, and other systems, establish PPS provider compensation tables and incentives. Develop compensation model and implementation plan.	Project		In Progress	07/27/2015	06/30/2016	07/27/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Develop a methodology to calculate criteria for distribution of incentive pool monies to reward performance of PPS partners.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 6. Obtain both Finance Committee and Board of Managers	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
approval of VBP transition plan.									
Task 7. Share transition plan with MCOs and secure their buy-in.	Project		Not Started	03/01/2016	12/31/2016	03/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 8. Engage MCOs and payers to agree to specific VBP rates. Specific rates and duration are contractually established.	Project		Not Started	06/01/2016	12/31/2016	06/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 9. Utilize feedback from PPS providers to ensure that improvement of desired patient outcomes, patient engagement, positive interventions, and avoidance of negative patient events are included in analysis of MCC programs and delivery models. Establish MCC provider compensation for patient outcomes.	Project		Not Started	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Communicate agreed-upon payment rates and procedures to PPS members.	Project		Not Started	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 11. Continuously monitor outcomes, trends, and other sources to verify agreed-upon measures are on target. Provide contracts, reports, payment vouchers, and/or other evidence demonstrating implementation of the compensation and performance management system.	Project		Not Started	06/01/2016	03/31/2017	06/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 12. Identify PPS providers who are not actively attempting to meet compensation and outcomes established by the Governance Committee. Corrective actions will be implemented for those PPS providers found noncompliant.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
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	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	04/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 1. Initiate outreach and navigation activities; partner with CBOs to implement patient activation activities.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Document partnerships with CBOs.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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Task 3. Define roles for, hire, and train navigators. Provide evidence of community health worker hiring, co-location agreements, and/or job descriptions.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Create communication and education plans for patients for inclusion in the Engagement Strategy and Plan (see IT Systems & Processes, milestone #3).	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Implement and deploy patient engagement systems including the patient portal, leveraging data from the MCC integrated EHR and data exchange/HIE environments.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Leverage the communication capabilities available in the patient portal to increase and improve patient-to-caregiver communications.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Utilize monitoring in population health management and data analytics for formative evaluation. Report on how many patients are engaged with community health workers.	Project		In Progress	07/01/2015	06/30/2017	07/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 8. Verify patient engagement is having the desired positive impact on outcomes and interventions.	Project		In Progress	07/01/2015	03/31/2019	07/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task 9. Adjust MCC processes and procedures to address gaps in patient engagement, outcomes, and other results via the PSC and Physician Performance Sub-Committee.	Project		In Progress	07/01/2015	03/31/2019	07/01/2015	03/31/2019	03/31/2019	DY4 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,										

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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, post-acute, long-term care, and community-based providers.										
Task 1. Create list of participating providers across the network.										
Task 2. Perform initial gap assessment to identify any gaps in the PPS network, particularly among community-based organizations (CBOs), pharmacists, dentists, behavioral health providers, and key primary care providers (PCPs). Utilize the Community Needs Assessment to identify key areas of focus.										
Task 3. Identify additional gaps by gathering information and recommendations from existing partners/members, the CBO Task Force, the "Voice of the Consumer" Sub-Committee, and geographic councils.										
Task 4. Issue requests for proposals (RFPs) for services to be performed by CBOs, including (but not limited to) cultural competency and health literacy training, Patient Activation coaching, and other services in connection with specific DSRIP projects (see Governance milestone #6).										
Task 5. Implement a strategy to maximize participation of all PPS partners in MCC projects and activities, provide frequent communication and education through a variety of channels including (but not limited to) biweekly newsletters emailed directly to participating providers and regular updates to the website. Conduct quarterly touchpoints to connect partners to projects and educate them on techniques for referring patients to other MCC partners.										
Task 6. As part of governance structure, establish a process to conduct periodic (quarterly) assessments of provider network in geographic areas throughout WNY to ensure that Medicaid beneficiaries have access to service providers.										
Task 7. Perform gap analysis of PPS providers' capabilities for EHR and data exchange (possess full EHR system, possess some EHR capabilities, or no EHR capabilities).										
Task 8. Develop comprehensive PPS partner database to house all data for readiness, implementation, and ongoing reporting. Partner database will have the capability to produce the provider network list and demonstrate changes to the network list.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 9. Develop ongoing review procedures to ensure that network partners have completed the necessary privacy and participation agreements to serve as a provider in the MCC network. Establish contractual agreements with partners.										
Task 10. Use these gaps, along with results of the Clinical Integration Needs Assessment, to develop a high-level roadmap for inclusion and integration of all partner organizations in the integrated delivery system (IDS).										
Task 11. Engage with local RHIO to develop increased EMR capacity.										
Task 12. Work with HEALTHeLINK to deploy data exchange alerts and messaging environment.										
Task 13. Establish and maintain working relationships with payers to engage them to support IDS strategy.										
Task 14. Identify payers and ancillary social service organization connectivity requirements; build data interfaces for these entities (if applicable).										
Task 15. Establish reports and secure dashboards so providers and stakeholders can monitor success and quality of data exchange and integration and make recommendations to the MCC IT Data Committee and individual providers to improve data exchange and integration.										
Task 16. IT Data Committee monitors reports and dashboards to identify trends and makes recommendations for improved data access, exchange, integration, and use. Recommendations are reported to the Board of Managers.										
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										

Millennium Collaborative Care (PPS ID:48)

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
collaborative care practices and integrated service delivery.										
Task 1. Produce and maintain list of the major health home (HH) organizations in WNY (five organizations). (There are no ACOs in WNY participating with MCC.)										
Task 2. Finalize and maintain written agreements with protocols for coordinating care.										
Task 3. Assess HH population health management systems and capabilities. Implement evidence-based models to establish linkages with HH population health and care management services. Create system for informing PPS partners of availability of these services.										
Task 4. Meet regularly with leadership from HHs to continue to refine collaborative care practices and integrated service delivery. Discuss how and the extent to which their care management services are connected to EDs, hospital discharge planning, behavioral health, home care services, and safety net PCPs and develop care management linkage recommendations. Maintain evidence of interaction.										
Task 5. Conduct gap analysis to identify gaps in HH members' data exchange and data access capabilities. Verify MCC IDS and EHR solution appropriately addresses these outliers, safety net organizations, behavioral health providers, and patient support members.										
Task 6. Begin providing periodic progress reports to demonstrate service integration; incorporate a population management strategy towards evolving into an IDS.										
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.										
Task Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task 1. Recruit and appoint qualified individual to oversee care management across PPS, enable development and dissemination of consistent information/processes, manage care management process, and promote integration and coordination among entities delivering care management.										
Task 2. Develop Care Transitions Strategy, as required in Clinical Integration, including process flow changes required to successfully implement IDS. Develop process flow diagrams demonstrating IDS processes. Leverage Community Health Workers (defined in detail in projects 2.b.iii. ED Care Triage, 2.b.vii. INTERACT, and 2.b.viii. Hospital/Home Care).										
Task 3. Work with project directors, Workforce Development Work Group, and others to determine the knowledge, competencies, and licensures required for care management to effectively work with patients to ensure they receive appropriate healthcare and community support.										
Task 4. Using CNA and other inputs, finalize inventory of WNY agencies providing care management services, including HHs, WNY Care Management Coalition, etc. Identify PPS partners and hospitals that must be linked for effective transitions of care.										
Task 5. Define care management continuum. For each role along the care continuum, describe criteria for patient referral, workflows, care planning process, responsibilities associated with transitions of care, policies and procedures, outcome measure reporting techniques, etc.										
Task 6. Identify cultural and language issues that must be addressed in care management, linkages with medical home care management services, and system for informing PPS partners of availability of chronic disease self-management services.										
Task 7. Convene three sub-regional meetings of individuals with knowledge of hospital-to-home transitions, hospital-to-nursing home transitions, and nursing home-to-skilled nursing facility										

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(SNF) transitions to assess current practices, identify data needs, review root cause analyses, and develop standards for maximizing effectiveness of transitions of care across the PPS. Maintain records including meeting schedules, agendas, minutes, and lists of attendees.										
Task 8. Finalize protocols for warm hand-offs of patients from intensive 30-day post-discharge care planning to HH care management services.										
Task 9. Engage trainers to provide introductory and ongoing care management training on policies and procedures to care managers. Provide written training materials, list of training dates, and number of staff trained.										
Task 10. Develop standards for utilizing existing EHR systems to capture key data and process measures related to DSRIP goals for reporting on care management.										
Task 11. Implement process for tracking care outside of hospital to ensure that all critical follow-up services and appointment reminders are followed. Process will include contract, report, periodic reporting of discharge plans uploaded into EHR, and other means of demonstrating implementation of the system.										
Task 12. In concert with IT, develop short- and mid-term IT platforms to use for tracking, monitoring, and reporting on care coordination transition processes and outcomes to ensure interoperability for all participating providers. Leverage existing PPS data exchange capabilities; reduce data redundancies.										
Task 13. Work with payers and others to clarify and develop care coordination and transition management billing processes; provide such information to providers.										
Task 14. Using evidence-based models, develop a plan to establish a chronic disease self-management program for use by providers throughout the PPS. Include catalog of existing chronic disease self-management providers. Collaborate with existing chronic disease self-management providers (CDSMP) to identify program offerings.										
Task 15. Clinical/Quality Committee, PSC, and Physician Performance Sub-Committee will monitor reports and dashboards to identify trends and make recommendations for improved data access,										

Millennium Collaborative Care (PPS ID:48)

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
exchange, integration, and use.										
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	15	30	45	60	75	90	102
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	30	60	90	120	150	180	210
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	2	4	6	8	10	12	14
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	7	14	21	28	35	42	49
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	6	12	18	24	36	42	48
Task PPS uses alerts and secure messaging functionality.										
Task 1. Conduct gap analysis to determine which providers have already completed PCMH/MU or other connectivity readiness assessment. - Is the practice/providers/patients currently connected to the HIE? - If not, is an agreement in place? - If so, what is the scope of the connectivity (% of providers; % of patients)? - Does EHR meet connectivity requirements of RHIO/SHIN-NY? - Name of EHR, version, and electronic functionalities in use										
Task 2. Develop strategy for low-cost data connectivity between Internet Service Providers (ISPs) (e.g., WNY R-AHEC) and local practice plans to determine minimum hardware and software requirements.										
Task 3. Gather results from readiness assessments already conducted.										

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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. Issue request for applications (RFA) or other action step for readiness assessment and transformation support services.										
Task 5. Select vendor or implement other structure for readiness assessment and transformation support services.										
Task 6. Identify funding model and/or PPS provider incentive model for EHR with the Finance Committee.										
Task 7. Connect PPS providers to enterprise DSRIP solution.										
Task 8. Systematically contact PPS providers to provide the recommended enterprise DSRIP solution.										
Task 9. Facilitate QE participation agreements with MCC providers.										
Task 10. Develop and implement training on use of enterprise DSRIP solution, including development of written materials. Track training dates and number of staff trained.										
Task 11. Implement and deploy alerts. Provide EHR vendor documentation, screenshots, and/or evidence of use of alerts.										
Task 12. Implement and deploy secure Direct messaging. Provide EHR vendor documentation, screenshots, and/or evidence of use of secure Direct messaging.										
Task 13. Implement and deploy patient record look-up. Provide EHR vendor documentation, screenshots, and/or evidence of use of patient record look-up.										
Task 14. Implement and deploy public health reporting capabilities. Provide EHR vendor documentation, screenshots, and/or samples of transactions to public health registries.										
Task 15. Continuously add PPS members when their EHR and data exchange capabilities reach the minimal level required to connect to the enterprise DSRIP solution.										
Task 16. PPS providers who are not actively exchanging systems will be addressed by the Physician Performance Sub-Committee. Corrective actions will be implemented for those PPS members found noncompliant.										

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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 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	15	30	45	60	75	90	105
Task 1. Conduct Safety Net MU stage 2 CMS/PCMH level 3 readiness assessment: a. Identify site-specific IT/care management leadership b. Determine current EHR PCMH/MU certification status c. Identify site-specific barriers and risks to implementing a MU/PCMH Level 3 certified EHR system										
Task 2. Facilitate engagement with MU/PCMH-certified EHR vendors as needed.										
Task 3. Establish PCMH/MU project implementation plan based on primary care practice readiness and certification status.										
Task 4. Review PCMH implementation plan for approval by the Clinical Quality Committee										
Task 5. Ensure practices have support through the PCMH implementation process either through a vendor or through MCC PCMH coordinators.										
Task 6. Establish a monthly review and measurement process of implementation progress and report to Clinical/Quality Committee.										
Task 7. Modify implementation plan as needed based on monthly review process.										
Task 8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.										
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.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task 1. Define IT requirements for initializing/maintaining/communicating risk stratification across settings, including means for electronic interfacing to the participating provider community and key data sharing.										
Task 2. Implement and deploy population health management risk stratification models and data analytics system leveraging data from the MCC integrated EHR and data exchange/HIE environments.										
Task 3. Identify gaps in care based on established clinical practice guidelines.										
Task 4. Define priority target population, pilot test, and implement risk-stratified patient registries (high risk, moderate risk, low risk, and well).										
Task 5. Track and monitor registry results and reductions in gaps in care to verify continuous improvement.										
Task 6. Establish the capabilities to report on patient engagement according to project reporting requirements.										
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	10	20	30	105	180	255	330
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task 1. Perform PCMH and MU readiness assessment 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
transformation support services for primary care practices: a. Issue RFA or other action step for readiness assessment and transformation support services; b. Select vendor(s).										
Task 2. Identify site-specific physician champions and site-specific IT/care management leadership. Determine PCMH/MU current status and identify site-specific barriers and risks to transformation.										
Task 3. Gather results from readiness assessments already conducted.										
Task 4. Based on CNA results and current data, identify primary care shortages in high-need areas.										
Task 5. Complete gap analysis for all MU/PCMH level 3 elements based on readiness assessment results.										
Task 6. Each site will change policy/procedures, roles/responsibilities, workflow for population health management/care management/care coordination during transitions, performance measurement, CAHPS measurement as needed to meet PCMH/MU standards.										
Task 7. Implement strategies to recruit PCPs to serve high-need areas. Provide status reporting of recruitment of PCPs, particularly in high-need areas, and monitor improvements in access via CAHPS measurement.										
Task 8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.										
Task 9. Maintain list of current/updated NCQA certified practices and EHR MU certifications.										
Task 10. Initiate PPS monitoring, oversight, and corrective action: a. PSC and Physician Performance Sub-Committee monitor reports and dashboards to identify trends in adherence to MU and PCMH level 3 standards b. Results will drive recommendations to improve meeting MU and PCMH measures c. Non-responsive PCPs will be addressed by the Physician Performance Sub-Committee with corrective action										
Milestone #8 Contract with Medicaid Managed Care Organizations and other										

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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
payers, as appropriate, as an integrated system and establish value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task 1. Assess ability for MCC to contract as IDS with MCOs.										
Task 2. Elicit input from MCOs on elements of a multi-year plan to transition to VBP system; present MCC's proposed multi-year plan to MCOs.										
Task 3. Depending on MCO cooperation, establish work plan that addresses establishing VBP arrangements, and goals to accomplish milestone 8.										
Task 4. Seek and obtain MCOs' revisions to plan. Secure MCOs' approval of plan. Catalog main issues/data needs that require resolution as part of the plan approval process.										
Task 5. Establish partner-specific incentives based on established utilization and quality metrics.										
Task 6. Utilize approved value-based payment (VBP) transition plan to guide agenda-setting in monthly meetings with MCOs.										
Task 7. Provide documentation of executed Medicaid Managed Care contracts.										
Task 8. Set up system to monitor progress with respect to evaluating the VBP transition plan's guideposts against actual results. Provide reports demonstrating percentage of total provider Medicaid reimbursement using value-based payments.										
Task 9. MCOs make recommendations to MCC on VBP arrangements. Implement programs, in-servicing information, and proposals for MCC partners based on MCO recommendations via the Physician Steering Committee.										
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.										

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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. Establish VBP Sub-Committee to include representation from behavioral health, adult- and child-care providers, and peers.										
Task 2. Charge VBP Sub-Committee (see Milestone #10) with responsibility of recommending structure and process to meet regularly with MCOs to review and evaluate costs, quality, utilization, and other relevant topics.										
Task 3. For each of the top four MCOs serving WNY (Independent Health, Fidelis, Blue Cross Blue Shield, and YourCare) define the following: participants, meeting schedule, agenda items, and other relevant processes for building PPS partnerships. Establish a process of reporting meeting outcomes/recommendations to stakeholders and PPS leadership. Maintain records of meeting agendas, attendees, minutes, and materials.										
Task 4. Ascertain from NYS DOH what recourses are available to PPS if an MCO does not agree to meet regularly or to engage in an organized VBP agenda with PPS.										
Task 5. Devise and secure buy-in from MCOs that they will adhere to a timetable for transitioning to a VBP system.										
Task 6. Establish agreed-upon data sources, utilization and performance metrics, reports, and dashboard.										
Task 7. Report Medicaid managed care metrics and opportunities to MCC Board of Manager committees.										
Task 8. Publish dashboards to MCC intranet for transparency with partners.										
Task 9. Identify opportunities for improvement based on the agreed-upon metrics and reports and develop process improvement strategies.										
Task 10. Measure and report progress of process improvement plans to MCC governance on a quarterly basis.										
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.										
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.										
Task 1. Establish VBP Sub-Committee under MCC's Finance Committee with representatives from finance, legal, medical staff, executive leadership, and others, to formulate a multi-year VBP transition plan.										
Task 2. Engage external expert/consultant to assist in and provide recommendations for development of five-year plan for transitioning to value-based reform system.										
Task 3. As part of plan, summarize process measures and clinical outcome benchmarks that will guide PPS's work over five years.										
Task 4. Based on data from population health, data analytics, PAM, coordination of care, HEDIS, predictive monitoring, risk stratification, and other systems, establish PPS provider compensation tables and incentives. Develop compensation model and implementation plan.										
Task 5. Develop a methodology to calculate criteria for distribution of incentive pool monies to reward performance of PPS partners.										
Task 6. Obtain both Finance Committee and Board of Managers approval of VBP transition plan.										
Task 7. Share transition plan with MCOs and secure their buy-in.										
Task 8. Engage MCOs and payers to agree to specific VBP rates. Specific rates and duration are contractually established.										
Task 9. Utilize feedback from PPS providers to ensure that improvement of desired patient outcomes, patient engagement, positive interventions, and avoidance of negative patient events are included in analysis of MCC programs and delivery models. Establish MCC provider compensation for patient outcomes.										
Task 10. Communicate agreed-upon payment rates and procedures to PPS members.										
Task 11. Continuously monitor outcomes, trends, and other sources to verify agreed-upon measures are on target. Provide contracts, reports, payment vouchers, and/or other evidence demonstrating										

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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
implementation of the compensation and performance management system.										
Task 12. Identify PPS providers who are not actively attempting to meet compensation and outcomes established by the Governance Committee. Corrective actions will be implemented for those PPS providers found noncompliant.										
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.										
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										
Task 1. Initiate outreach and navigation activities; partner with CBOs to implement patient activation activities.										
Task 2. Document partnerships with CBOs.										
Task 3. Define roles for, hire, and train navigators. Provide evidence of community health worker hiring, co-location agreements, and/or job descriptions.										
Task 4. Create communication and education plans for patients for inclusion in the Engagement Strategy and Plan (see IT Systems & Processes, milestone #3).										
Task 5. Implement and deploy patient engagement systems including the patient portal, leveraging data from the MCC integrated EHR and data exchange/HIE environments.										
Task 6. Leverage the communication capabilities available in the patient portal to increase and improve patient-to-caregiver communications.										
Task 7. Utilize monitoring in population health management and data analytics for formative evaluation. Report on how many patients are engaged with community health workers.										
Task 8. Verify patient engagement is having the desired positive impact on outcomes and interventions.										
Task 9. Adjust MCC processes and procedures to address gaps in										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
patient engagement, outcomes, and other results via the PSC and Physician Performance Sub-Committee.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.										
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
Task 1. Create list of participating providers across the network.										
Task 2. Perform initial gap assessment to identify any gaps in the PPS network, particularly among community-based organizations (CBOs), pharmacists, dentists, behavioral health providers, and key primary care providers (PCPs). Utilize the Community Needs Assessment to identify key areas of focus.										
Task 3. Identify additional gaps by gathering information and recommendations from existing partners/members, the CBO Task Force, the "Voice of the Consumer" Sub-Committee, and geographic councils.										
Task 4. Issue requests for proposals (RFPs) for services to be performed by CBOs, including (but not limited to) cultural competency and health literacy training, Patient Activation coaching, and other services in connection with specific DSRIP projects (see Governance milestone #6).										
Task 5. Implement a strategy to maximize participation of all PPS partners in MCC projects and activities, provide frequent communication and education through a variety of channels including (but not limited to) biweekly newsletters emailed directly to participating providers and regular updates to the website. Conduct quarterly touchpoints to connect partners to projects and educate them on techniques for referring patients to other MCC partners.										

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Task 6. As part of governance structure, establish a process to conduct periodic (quarterly) assessments of provider network in geographic areas throughout WNY to ensure that Medicaid beneficiaries have access to service providers.										
Task 7. Perform gap analysis of PPS providers' capabilities for EHR and data exchange (possess full EHR system, possess some EHR capabilities, or no EHR capabilities).										
Task 8. Develop comprehensive PPS partner database to house all data for readiness, implementation, and ongoing reporting. Partner database will have the capability to produce the provider network list and demonstrate changes to the network list.										
Task 9. Develop ongoing review procedures to ensure that network partners have completed the necessary privacy and participation agreements to serve as a provider in the MCC network. Establish contractual agreements with partners.										
Task 10. Use these gaps, along with results of the Clinical Integration Needs Assessment, to develop a high-level roadmap for inclusion and integration of all partner organizations in the integrated delivery system (IDS).										
Task 11. Engage with local RHIO to develop increased EMR capacity.										
Task 12. Work with HEALTHeLINK to deploy data exchange alerts and messaging environment.										
Task 13. Establish and maintain working relationships with payers to engage them to support IDS strategy.										
Task 14. Identify payers and ancillary social service organization connectivity requirements; build data interfaces for these entities (if applicable).										
Task 15. Establish reports and secure dashboards so providers and stakeholders can monitor success and quality of data exchange and integration and make recommendations to the MCC IT Data Committee and individual providers to improve data exchange and integration.										
Task 16. IT Data Committee monitors reports and dashboards to identify trends and makes recommendations for improved data										

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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
access, exchange, integration, and use. Recommendations are reported to the Board of Managers.										
Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.										
Task PPS produces a list of participating HHs and ACOs.										
Task Participating HHs and ACOs demonstrate real service integration which incorporates a population management strategy towards evolving into an IDS.										
Task Regularly scheduled formal meetings are held to develop collaborative care practices and integrated service delivery.										
Task 1. Produce and maintain list of the major health home (HH) organizations in WNY (five organizations). (There are no ACOs in WNY participating with MCC.)										
Task 2. Finalize and maintain written agreements with protocols for coordinating care.										
Task 3. Assess HH population health management systems and capabilities. Implement evidence-based models to establish linkages with HH population health and care management services. Create system for informing PPS partners of availability of these services.										
Task 4. Meet regularly with leadership from HHs to continue to refine collaborative care practices and integrated service delivery. Discuss how and the extent to which their care management services are connected to EDs, hospital discharge planning, behavioral health, home care services, and safety net PCPs and develop care management linkage recommendations. Maintain evidence of interaction.										
Task 5. Conduct gap analysis to identify gaps in HH members' data exchange and data access capabilities. Verify MCC IDS and EHR solution appropriately addresses these outliers, safety net organizations, behavioral health providers, and patient support members.										
Task 6. Begin providing periodic progress reports to demonstrate service integration; incorporate a population management										

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DSRIP Implementation Plan Project

Millennium Collaborative Care (PPS ID:48)

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
strategy towards evolving into an IDS.										
Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.										
Task Clinically Interoperable System is in place for all participating providers.										
Task PPS has protocols in place for care coordination and has identified process flow changes required to successfully implement IDS.										
Task PPS has process for tracking care outside of hospitals to ensure that all critical follow-up services and appointment reminders are followed.										
Task PPS trains staff on IDS protocols and processes.										
Task 1. Recruit and appoint qualified individual to oversee care management across PPS, enable development and dissemination of consistent information/processes, manage care management process, and promote integration and coordination among entities delivering care management.										
Task 2. Develop Care Transitions Strategy, as required in Clinical Integration, including process flow changes required to successfully implement IDS. Develop process flow diagrams demonstrating IDS processes. Leverage Community Health Workers (defined in detail in projects 2.b.iii. ED Care Triage, 2.b.vii. INTERACT, and 2.b.viii. Hospital/Home Care).										
Task 3. Work with project directors, Workforce Development Work Group, and others to determine the knowledge, competencies, and licensures required for care management to effectively work with patients to ensure they receive appropriate healthcare and community support.										
Task 4. Using CNA and other inputs, finalize inventory of WNY agencies providing care management services, including HHs, WNY Care Management Coalition, etc. Identify PPS partners and hospitals that must be linked for effective transitions of care.										
Task 5. Define care management continuum. For each role along the										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
care continuum, describe criteria for patient referral, workflows, care planning process, responsibilities associated with transitions of care, policies and procedures, outcome measure reporting techniques, etc.										
Task 6. Identify cultural and language issues that must be addressed in care management, linkages with medical home care management services, and system for informing PPS partners of availability of chronic disease self-management services.										
Task 7. Convene three sub-regional meetings of individuals with knowledge of hospital-to-home transitions, hospital-to-nursing home transitions, and nursing home-to-skilled nursing facility (SNF) transitions to assess current practices, identify data needs, review root cause analyses, and develop standards for maximizing effectiveness of transitions of care across the PPS. Maintain records including meeting schedules, agendas, minutes, and lists of attendees.										
Task 8. Finalize protocols for warm hand-offs of patients from intensive 30-day post-discharge care planning to HH care management services.										
Task 9. Engage trainers to provide introductory and ongoing care management training on policies and procedures to care managers. Provide written training materials, list of training dates, and number of staff trained.										
Task 10. Develop standards for utilizing existing EHR systems to capture key data and process measures related to DSRIP goals for reporting on care management.										
Task 11. Implement process for tracking care outside of hospital to ensure that all critical follow-up services and appointment reminders are followed. Process will include contract, report, periodic reporting of discharge plans uploaded into EHR, and other means of demonstrating implementation of the system.										
Task 12. In concert with IT, develop short- and mid-term IT platforms to use for tracking, monitoring, and reporting on care coordination transition processes and outcomes to ensure interoperability for all participating providers. Leverage existing PPS data exchange capabilities; reduce data redundancies.										
Task 13. Work with payers and others to clarify and develop 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
coordination and transition management billing processes; provide such information to providers.										
Task 14. Using evidence-based models, develop a plan to establish a chronic disease self-management program for use by providers throughout the PPS. Include catalog of existing chronic disease self-management providers. Collaborate with existing chronic disease self-management providers (CDSMP) to identify program offerings.										
Task 15. Clinical/Quality Committee, PSC, and Physician Performance Sub-Committee will monitor reports and dashboards to identify trends and make recommendations for improved data access, exchange, integration, and use.										
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.	120	135	150	200	225	252	252	252	252	252
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	240	270	300	330	340	343	343	343	343	343
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	16	18	20	22	24	25	25	25	25	25
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	56	72	82	87	90	92	92	92	92	92
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	53	59	60	62	65	69	69	69	69	69
Task PPS uses alerts and secure messaging functionality.										
Task 1. Conduct gap analysis to determine which providers have already completed PCMH/MU or other connectivity readiness assessment. - Is the practice/providers/patients currently connected to the HIE? - If not, is an agreement in place?										

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- If so, what is the scope of the connectivity (% of providers; % of patients)? - Does EHR meet connectivity requirements of RHIO/SHIN-NY? - Name of EHR, version, and electronic functionalities in use										
Task 2. Develop strategy for low-cost data connectivity between Internet Service Providers (ISPs) (e.g., WNY R-AHEC) and local practice plans to determine minimum hardware and software requirements.										
Task 3. Gather results from readiness assessments already conducted.										
Task 4. Issue request for applications (RFA) or other action step for readiness assessment and transformation support services.										
Task 5. Select vendor or implement other structure for readiness assessment and transformation support services.										
Task 6. Identify funding model and/or PPS provider incentive model for EHR with the Finance Committee.										
Task 7. Connect PPS providers to enterprise DSRIP solution.										
Task 8. Systematically contact PPS providers to provide the recommended enterprise DSRIP solution.										
Task 9. Facilitate QE participation agreements with MCC providers.										
Task 10. Develop and implement training on use of enterprise DSRIP solution, including development of written materials. Track training dates and number of staff trained.										
Task 11. Implement and deploy alerts. Provide EHR vendor documentation, screenshots, and/or evidence of use of alerts.										
Task 12. Implement and deploy secure Direct messaging. Provide EHR vendor documentation, screenshots, and/or evidence of use of secure Direct messaging.										
Task 13. Implement and deploy patient record look-up. Provide EHR vendor documentation, screenshots, and/or evidence of use of patient record look-up.										
Task										

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14. Implement and deploy public health reporting capabilities. Provide EHR vendor documentation, screenshots, and/or samples of transactions to public health registries.										
Task 15. Continuously add PPS members when their EHR and data exchange capabilities reach the minimal level required to connect to the enterprise DSRIP solution.										
Task 16. PPS providers who are not actively exchanging systems will be addressed by the Physician Performance Sub-Committee. Corrective actions will be implemented for those PPS members found noncompliant.										
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.	120	135	150	200	225	252	252	252	252	252
Task 1. Conduct Safety Net MU stage 2 CMS/PCMH level 3 readiness assessment: a. Identify site-specific IT/care management leadership b. Determine current EHR PCMH/MU certification status c. Identify site-specific barriers and risks to implementing a MU/PCMH Level 3 certified EHR system										
Task 2. Facilitate engagement with MU/PCMH-certified EHR vendors as needed.										
Task 3. Establish PCMH/MU project implementation plan based on primary care practice readiness and certification status.										
Task 4. Review PCMH implementation plan for approval by the Clinical Quality Committee										
Task 5. Ensure practices have support through the PCMH implementation process either through a vendor or through MCC PCMH coordinators.										
Task 6. Establish a monthly review and measurement process of										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
implementation progress and report to Clinical/Quality Committee.										
Task 7. Modify implementation plan as needed based on monthly review process.										
Task 8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.										
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. Define IT requirements for initializing/maintaining/communicating risk stratification across settings, including means for electronic interfacing to the participating provider community and key data sharing.										
Task 2. Implement and deploy population health management risk stratification models and data analytics system leveraging data from the MCC integrated EHR and data exchange/HIE environments.										
Task 3. Identify gaps in care based on established clinical practice guidelines.										
Task 4. Define priority target population, pilot test, and implement risk-stratified patient registries (high risk, moderate risk, low risk, and well).										
Task 5. Track and monitor registry results and reductions in gaps in care to verify continuous improvement.										
Task 6. Establish the capabilities to report on patient engagement according to project reporting requirements.										
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.										

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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.	405	480	555	630	650	653	653	653	653	653
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task 1. Perform PCMH and MU readiness assessment and transformation support services for primary care practices: a. Issue RFA or other action step for readiness assessment and transformation support services; b. Select vendor(s).										
Task 2. Identify site-specific physician champions and site-specific IT/care management leadership. Determine PCMH/MU current status and identify site-specific barriers and risks to transformation.										
Task 3. Gather results from readiness assessments already conducted.										
Task 4. Based on CNA results and current data, identify primary care shortages in high-need areas.										
Task 5. Complete gap analysis for all MU/PCMH level 3 elements based on readiness assessment results.										
Task 6. Each site will change policy/procedures, roles/responsibilities, workflow for population health management/care management/care coordination during transitions, performance measurement, CAHPS measurement as needed to meet PCMH/MU standards.										
Task 7. Implement strategies to recruit PCPs to serve high-need areas. Provide status reporting of recruitment of PCPs, particularly in high-need areas, and monitor improvements in access via CAHPS measurement.										
Task 8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.										
Task 9. Maintain list of current/updated NCQA certified practices and										

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EHR MU certifications.										
Task 10. Initiate PPS monitoring, oversight, and corrective action: a. PSC and Physician Performance Sub-Committee monitor reports and dashboards to identify trends in adherence to MU and PCMH level 3 standards b. Results will drive recommendations to improve meeting MU and PCMH measures c. Non-responsive PCPs will be addressed by the Physician Performance Sub-Committee with corrective action										
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.										
Task Medicaid Managed Care contract(s) are in place that include value-based payments.										
Task 1. Assess ability for MCC to contract as IDS with MCOs.										
Task 2. Elicit input from MCOs on elements of a multi-year plan to transition to VBP system; present MCC's proposed multi-year plan to MCOs.										
Task 3. Depending on MCO cooperation, establish work plan that addresses establishing VBP arrangements, and goals to accomplish milestone 8.										
Task 4. Seek and obtain MCOs' revisions to plan. Secure MCOs' approval of plan. Catalog main issues/data needs that require resolution as part of the plan approval process.										
Task 5. Establish partner-specific incentives based on established utilization and quality metrics.										
Task 6. Utilize approved value-based payment (VBP) transition plan to guide agenda-setting in monthly meetings with MCOs.										
Task 7. Provide documentation of executed Medicaid Managed Care contracts.										
Task 8. Set up system to monitor progress with respect to evaluating the VBP transition plan's guideposts against actual results. Provide reports demonstrating percentage of total provider										

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Medicaid reimbursement using value-based payments.										
Task 9. MCOs make recommendations to MCC on VBP arrangements. Implement programs, in-servicing information, and proposals for MCC partners based on MCO recommendations via the Physician Steering Committee.										
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.										
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.										
Task 1. Establish VBP Sub-Committee to include representation from behavioral health, adult- and child-care providers, and peers.										
Task 2. Charge VBP Sub-Committee (see Milestone #10) with responsibility of recommending structure and process to meet regularly with MCOs to review and evaluate costs, quality, utilization, and other relevant topics.										
Task 3. For each of the top four MCOs serving WNY (Independent Health, Fidelis, Blue Cross Blue Shield, and YourCare) define the following: participants, meeting schedule, agenda items, and other relevant processes for building PPS partnerships. Establish a process of reporting meeting outcomes/recommendations to stakeholders and PPS leadership. Maintain records of meeting agendas, attendees, minutes, and materials.										
Task 4. Ascertain from NYS DOH what recourses are available to PPS if an MCO does not agree to meet regularly or to engage in an organized VBP agenda with PPS.										
Task 5. Devise and secure buy-in from MCOs that they will adhere to a timetable for transitioning to a VBP system.										
Task 6. Establish agreed-upon data sources, utilization and performance metrics, reports, and dashboard.										
Task 7. Report Medicaid managed care metrics and opportunities to MCC Board of Manager committees.										
Task 8. Publish dashboards to MCC intranet for transparency with										

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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
partners.										
Task 9. Identify opportunities for improvement based on the agreed-upon metrics and reports and develop process improvement strategies.										
Task 10. Measure and report progress of process improvement plans to MCC governance on a quarterly basis.										
Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.										
Task PPS submitted a growth plan outlining the strategy to evolve provider compensation model to incentive-based compensation										
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.										
Task 1. Establish VBP Sub-Committee under MCC's Finance Committee with representatives from finance, legal, medical staff, executive leadership, and others, to formulate a multi-year VBP transition plan.										
Task 2. Engage external expert/consultant to assist in and provide recommendations for development of five-year plan for transitioning to value-based reform system.										
Task 3. As part of plan, summarize process measures and clinical outcome benchmarks that will guide PPS's work over five years.										
Task 4. Based on data from population health, data analytics, PAM, coordination of care, HEDIS, predictive monitoring, risk stratification, and other systems, establish PPS provider compensation tables and incentives. Develop compensation model and implementation plan.										
Task 5. Develop a methodology to calculate criteria for distribution of incentive pool monies to reward performance of PPS partners.										
Task 6. Obtain both Finance Committee and Board of Managers approval of VBP transition plan.										
Task 7. Share transition plan with MCOs and secure their buy-in.										

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Task 8. Engage MCOs and payers to agree to specific VBP rates. Specific rates and duration are contractually established.										
Task 9. Utilize feedback from PPS providers to ensure that improvement of desired patient outcomes, patient engagement, positive interventions, and avoidance of negative patient events are included in analysis of MCC programs and delivery models. Establish MCC provider compensation for patient outcomes.										
Task 10. Communicate agreed-upon payment rates and procedures to PPS members.										
Task 11. Continuously monitor outcomes, trends, and other sources to verify agreed-upon measures are on target. Provide contracts, reports, payment vouchers, and/or other evidence demonstrating implementation of the compensation and performance management system.										
Task 12. Identify PPS providers who are not actively attempting to meet compensation and outcomes established by the Governance Committee. Corrective actions will be implemented for those PPS providers found noncompliant.										
Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.										
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.										
Task 1. Initiate outreach and navigation activities; partner with CBOs to implement patient activation activities.										
Task 2. Document partnerships with CBOs.										
Task 3. Define roles for, hire, and train navigators. Provide evidence of community health worker hiring, co-location agreements, and/or job descriptions.										
Task 4. Create communication and education plans for patients for inclusion in the Engagement Strategy and Plan (see IT Systems & Processes, milestone #3).										

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Task 5. Implement and deploy patient engagement systems including the patient portal, leveraging data from the MCC integrated EHR and data exchange/HIE environments.										
Task 6. Leverage the communication capabilities available in the patient portal to increase and improve patient-to-caregiver communications.										
Task 7. Utilize monitoring in population health management and data analytics for formative evaluation. Report on how many patients are engaged with community health workers.										
Task 8. Verify patient engagement is having the desired positive impact on outcomes and interventions.										
Task 9. Adjust MCC processes and procedures to address gaps in patient engagement, outcomes, and other results via the PSC and Physician Performance Sub-Committee.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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 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.	

Milestone Review Status

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 2.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.

Financial distributions from the NYS DOH may be impacted if quarterly goals are not attained. Resistance to change and IT system limitations may impact ability to attain project goals.

Site-specific challenges may interfere with the successful implementation and integration of this project at each site and the ability of the initiative to achieve project milestones. MCC will develop the project in a way that allows flexibility and accommodates variability across sites while ensuring each site follows uniform procedures and reports on standardized metrics.

Limited availability of primary care appointments within four weeks of an ED visit for high-risk ED patients will negatively impact the project's ability to meet quarterly performance deliverables. The broader DSRIP initiative will address availability of primary care in the region.

Insurance will not pay unless the patient sees their identified PCP. If an appointment with the patient's identified PCP is not available within four weeks, he or she must contact the insurance company, change PCPs, then make the appointment. Reach out to insurance companies to streamline process or adjust policies.

Inadequate staffing/resources at each site will affect ability to reach goals and target. Start by implementing the project at EDs with higher volume. Develop and utilize virtual care coordinator/CHW resources to allow "sharing" of resources between high and low ED volume sites.

Lack of access to 24x7 primary care scheduling systems will affect the project's ability to schedule PCP appointments for patients and communicate this information to patients at the time of their ED visit. Work with sites for real-time access to scheduling systems, starting with safety net providers.

As the CHW will be a new role for most of the EDs, there is risk of confusion about this new role, duplication, and lack of support. The role of the CHW and other staff in the ED must be well defined and shared with all ED personnel.

Lack of availability (or awareness) of community resources to address barriers to access will affect the patient's ability to get to the scheduled PCP appointments. Develop partnerships with community service providers. Work with health literacy experts to publicize available resources.

Inadequate communication between the ED and PCPs creates discontinuity of care, causes potential duplication of tests, and affects timely treatment of patient issues at the appropriate setting. Transmit patient ED visit information to PCPs. Patients will receive a healthcare folder with discharge summary/instructions to take to PCP.

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Failure to provide consistent messaging for patients regarding appropriate use of healthcare services at all points of access will negatively impact the ability of MCC to change patient utilization behavior. Coordinate with other PPSs in WNY to develop standardized messaging.

High-risk ED patients are often difficult to engage and contact for follow-up. CHWs go into the field when necessary to "find" patients; partner with other agencies that may be serving the patient to reconnect them to care.

CHW and ED staff are not properly trained to engage patients, identify barriers to care, refer patients to needed services, and motivate patients to utilize PCP services. CHWs will receive training to prepare them and educate them on processes and procedures.

Lack of communication or inadequate processes could lead to patients falling through the cracks or duplication of services. Each site will facilitate a monthly meeting to discuss processes for identifying patients, roles, missed patients, referrals, challenges, and develop corrective action plans.

A new application built on the Salesforce.com platform to supports patient encounter tracking and the project is transitioning to the automated tool. It has been piloted at the first ED to work through the usual issues.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	14,300

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
1,221	2,080	69.33%	920	14.55%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (3,000)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ethelen	Baseline or Performance Documentation	48_PMDL2715_1_3_20160202173443_2biii_PE_registry_DY1Q3.xlsx	Patient engagement registry showing 859 patients	02/02/2016 05:35 PM

Narrative Text :

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

patients previously reported in DY1 Q2: 1221. new patients engaged in DY1 Q3: 859. cumulative total: 2080

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Establish ED care triage program for at-risk populations	Project	N/A	In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Stand up program based on project requirements	Project		In Progress	04/01/2015	06/30/2017	04/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task 1. ECMC: Identify facility participants	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2. ECMC: Execute letter of intent/participation agreement	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 3. ECMC: Develop implementation approach, training program, tracking and reporting mechanisms	Project		Completed	04/01/2015	05/29/2015	04/01/2015	05/29/2015	06/30/2015	DY1 Q1
Task 4. ECMC: Refine processes based on learnings from pilot program	Project		Completed	06/01/2015	06/12/2015	06/01/2015	06/12/2015	06/30/2015	DY1 Q1
Task 5. ECMC: Introduce program and provide training	Project		Completed	06/01/2015	06/26/2015	06/01/2015	06/26/2015	06/30/2015	DY1 Q1
Task 6. ECMC: Implement program	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 7. NFMMC: Identify facility participants	Project		Completed	05/01/2015	06/30/2015	05/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 8. NFMMC: Execute letter of intent/participation agreement	Project		Completed	05/01/2015	06/30/2015	05/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 9. NFMMC: Perform assessment, modify approach for facility	Project		Completed	05/01/2015	06/30/2015	05/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 10. NFMMC: Hire and train patient navigators	Project		Completed	05/01/2015	07/14/2015	05/01/2015	07/14/2015	09/30/2015	DY1 Q2
Task 11. NFMMC: Implement program	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 12. Olean and Cuba: Identify facility participants	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task	Project		Completed	08/03/2015	10/30/2015	08/03/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
13. Olean and Cuba: Execute letter of intent or participation agreement (if applicable)									
Task 14. Olean and Cuba: Perform assessment, modify approach for facility	Project		Completed	08/03/2015	10/30/2015	08/03/2015	10/30/2015	12/31/2015	DY1 Q3
Task 15. Olean and Cuba: Hire and train patient navigators	Project		Completed	10/01/2015	11/13/2015	10/01/2015	12/18/2015	12/31/2015	DY1 Q3
Task 16. Olean and Cuba: Implement program	Project		Completed	11/02/2015	12/31/2015	11/02/2015	12/31/2015	12/31/2015	DY1 Q3
Task 17. Buffalo General Hospital: Identify facility participants	Project		Completed	11/02/2015	12/31/2015	11/02/2015	12/31/2015	12/31/2015	DY1 Q3
Task 18. Buffalo General Hospital: Execute letter of intent or participation agreement (if applicable)	Project		In Progress	11/02/2015	12/31/2015	11/02/2015	03/31/2016	03/31/2016	DY1 Q4
Task 19. Buffalo General Hospital: Perform assessment, modify approach for facility	Project		Not Started	11/02/2015	12/31/2015	01/04/2016	02/19/2016	03/31/2016	DY1 Q4
Task 20. Buffalo General Hospital: Hire and train patient navigators	Project		Not Started	12/01/2015	01/15/2016	01/04/2016	03/18/2016	03/31/2016	DY1 Q4
Task 21. Buffalo General Hospital: Implement program	Project		Not Started	01/01/2016	03/31/2016	03/21/2016	06/30/2016	06/30/2016	DY2 Q1
Task 22. Women's and Children's: Identify facility participants	Project		Not Started	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 23. Women's and Children's: Execute letter of intent or participation agreement (if applicable)	Project		Not Started	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 24. Women's and Children's: Perform assessment, modify approach for facility	Project		Not Started	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 25. Women's and Children's: Hire and train patient navigators	Project		Not Started	03/01/2016	04/15/2016	03/01/2016	04/15/2016	06/30/2016	DY2 Q1
Task 26. Women's and Children's: Implement program	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 27. Eastern Niagara: Identify facility participants	Project		Not Started	05/03/2016	06/30/2016	05/03/2016	06/30/2016	06/30/2016	DY2 Q1
Task 28. Eastern Niagara: Execute letter of intent or participation agreement (if applicable)	Project		Not Started	05/03/2016	06/30/2016	05/03/2016	06/30/2016	06/30/2016	DY2 Q1
Task	Project		Not Started	05/03/2016	06/30/2016	05/03/2016	06/30/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
29. Eastern Niagara: Perform assessment, modify approach for facility									
Task 30. Eastern Niagara: Hire and train patient navigators	Project		Not Started	06/01/2016	07/18/2016	06/01/2016	07/18/2016	09/30/2016	DY2 Q2
Task 31. Eastern Niagara: Implement program	Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 32. Millard Fillmore: Identify facility participants	Project		Not Started	08/01/2016	09/30/2016	08/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 33. Millard Fillmore: Execute letter of intent or participation agreement (if applicable)	Project		Not Started	08/01/2016	09/30/2016	08/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 34. Millard Fillmore: Perform assessment, modify approach for facility	Project		Not Started	08/01/2016	09/30/2016	08/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 35. Millard Fillmore: Hire and train patient navigators	Project		Not Started	09/01/2016	10/18/2016	09/01/2016	10/18/2016	12/31/2016	DY2 Q3
Task 36. Millard Fillmore: Implement program	Project		Not Started	10/03/2016	12/30/2016	10/03/2016	12/30/2016	12/31/2016	DY2 Q3
Task 37. DeGraff: Identify facility participants	Project		Not Started	11/01/2016	12/30/2016	11/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 38. DeGraff: Execute letter of intent or participation agreement (if applicable)	Project		Not Started	11/01/2016	12/30/2016	11/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 39. DeGraff: Perform assessment, modify approach for facility	Project		Not Started	11/01/2016	12/31/2016	11/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 40. DeGraff: Hire and train patient navigators	Project		Not Started	12/01/2016	01/17/2017	12/01/2016	01/17/2017	03/31/2017	DY2 Q4
Task 41. DeGraff: Implement program	Project		Not Started	01/02/2017	03/31/2017	01/02/2017	03/31/2017	03/31/2017	DY2 Q4
Task 42. Lakeshore/TLC: Identify facility participants	Project		Not Started	02/01/2017	03/31/2017	02/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 43. Lakeshore/TLC: Execute letter of intent or participation agreement (if applicable)	Project		Not Started	02/01/2017	05/30/2017	02/01/2017	05/30/2017	06/30/2017	DY3 Q1
Task 44. Lakeshore/TLC: Perform assessment, modify approach for facility	Project		Not Started	02/01/2017	03/31/2017	02/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 45. Lakeshore/TLC: Hire and train patient navigators	Project		Not Started	03/01/2017	04/17/2017	03/01/2017	04/17/2017	06/30/2017	DY3 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 46. Lakeshore/TLC: Implement program	Project		Not Started	04/03/2017	06/30/2017	04/03/2017	06/30/2017	06/30/2017	DY3 Q1
Task 47. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of approach, and allow for continuous improvement over time. Lessons learned will be shared from one implementation to the next.	Project		In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
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	08/03/2015	03/30/2018	08/03/2015	03/30/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/03/2015	03/30/2018	08/03/2015	03/30/2018	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	08/03/2015	03/30/2018	08/03/2015	03/30/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/03/2015	03/30/2018	08/03/2015	03/30/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Hospital	In Progress	08/03/2015	03/30/2018	08/03/2015	03/30/2018	03/31/2018	DY3 Q4
Task 1. Develop protocol to provide project roster updates to Chief Reporting Officer (CRO) for update to MCC provider database.	Project		Completed	08/03/2015	08/31/2015	08/03/2015	08/31/2015	09/30/2015	DY1 Q2
Task 2. Ensure that CRO has established crosswalks for NCQA and Meaningful Use certification levels in provider database.	Project		Completed	09/01/2015	10/30/2015	09/01/2015	10/30/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 3. Obtain quarterly project roster reporting including provider NCQA and Meaningful Use status from CRO.	Project		Completed	10/01/2015	10/15/2015	10/01/2015	10/15/2015	12/31/2015	DY1 Q3
Task 4. Continue to monitor and report status of participating PCPs on a quarterly basis.	Project		Not Started	01/04/2016	03/30/2018	01/04/2016	03/30/2018	03/31/2018	DY3 Q4
Task 5. Ensure all providers utilize HEALTHeLINK for encounter notifications.	Project		In Progress	09/01/2015	03/30/2018	09/01/2015	03/30/2018	03/31/2018	DY3 Q4
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
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	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. Develop protocols to direct patient navigators in identifying a PCP and establishing an immediate appointment for patients who do not have a PCP.	Project		Completed	04/01/2015	05/30/2015	04/01/2015	05/30/2015	06/30/2015	DY1 Q1
Task 2. Refine protocols for obtaining PCP appointments for patients without a PCP.	Project		Completed	06/01/2015	06/30/2015	06/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 3. Develop protocols to assist patient navigators in identifying needed community support services, depending on patient need.	Project		Completed	04/01/2015	05/30/2015	04/01/2015	05/30/2015	06/30/2015	DY1 Q1
Task 4. Refine protocols for identifying needed community support services.	Project		Completed	06/01/2015	06/30/2015	06/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task	Project		Completed	04/01/2015	05/29/2015	04/01/2015	05/29/2015	06/30/2015	DY1 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
5. Develop protocols to direct patient navigators in establishing an immediate appointment for patients who have a PCP.									
Task 6. Refine protocols for obtaining PCP appointments for patients who have a PCP.	Project		Completed	06/01/2015	06/30/2015	06/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task 7. Create process to export and download encounter information for quarterly reporting.	Project		Completed	09/03/2015	09/16/2015	09/03/2015	09/16/2015	09/30/2015	DY1 Q2
Task 8. Deliver first quarterly encounter reporting.	Project		Completed	10/01/2015	10/14/2015	10/01/2015	10/14/2015	12/31/2015	DY1 Q3
Task 9. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of approach, and allow for continuous improvement over time	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
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	Completed	04/01/2015	04/01/2015	04/01/2015	04/01/2015	06/30/2015	DY1 Q1
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	Provider	Safety Net Hospital	Completed	04/01/2015	04/01/2015	04/01/2015	04/01/2015	06/30/2015	DY1 Q1
Task not applicable (optional)	Project		Completed	04/01/2015	04/01/2015	04/01/2015	04/01/2015	06/30/2015	DY1 Q1
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	06/01/2015	03/31/2017	06/01/2015	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	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Complete development of Salesforce.com patient encounter/tracking solution.	Project		Completed	06/01/2015	07/30/2015	06/01/2015	07/30/2015	09/30/2015	DY1 Q2
Task 2. Obtain MCC licensing and instance for Salesforce.com.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Import encounters tracked in Excel spreadsheet into Salesforce.com.	Project		Completed	08/03/2015	08/07/2015	08/03/2015	08/07/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 4. Manually enter any data missing from manual forms into Salesforce.com.	Project		Completed	08/10/2015	08/28/2015	08/10/2015	08/28/2015	09/30/2015	DY1 Q2
Task 5. Port data from UEMS Salesforce.com instance to new MCC license.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Delivery quarterly encounter reporting.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Establish ED care triage program for at-risk populations										
Task Stand up program based on project requirements										
Task 1. ECMC: Identify facility participants										
Task 2. ECMC: Execute letter of intent/participation agreement										
Task 3. ECMC: Develop implementation approach, training program, tracking and reporting mechanisms										
Task 4. ECMC: Refine processes based on learnings from pilot program										
Task 5. ECMC: Introduce program and provide training										
Task 6. ECMC: Implement program										
Task 7. NFMMC: Identify facility participants										
Task 8. NFMMC: Execute letter of intent/participation agreement										
Task 9. NFMMC: Perform assessment, modify approach for facility										
Task 10. NFMMC: Hire and train patient navigators										
Task 11. NFMMC: Implement program										
Task 12. Olean and Cuba: Identify facility 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 13. Olean and Cuba: Execute letter of intent or participation agreement (if applicable)										
Task 14. Olean and Cuba: Perform assessment, modify approach for facility										
Task 15. Olean and Cuba: Hire and train patient navigators										
Task 16. Olean and Cuba: Implement program										
Task 17. Buffalo General Hospital: Identify facility participants										
Task 18. Buffalo General Hospital: Execute letter of intent or participation agreement (if applicable)										
Task 19. Buffalo General Hospital: Perform assessment, modify approach for facility										
Task 20. Buffalo General Hospital: Hire and train patient navigators										
Task 21. Buffalo General Hospital: Implement program										
Task 22. Women's and Children's: Identify facility participants										
Task 23. Women's and Children's: Execute letter of intent or participation agreement (if applicable)										
Task 24. Women's and Children's: Perform assessment, modify approach for facility										
Task 25. Women's and Children's: Hire and train patient navigators										
Task 26. Women's and Children's: Implement program										
Task 27. Eastern Niagara: Identify facility participants										
Task 28. Eastern Niagara: Execute letter of intent or participation agreement (if applicable)										
Task 29. Eastern Niagara: Perform assessment, modify approach for facility										
Task 30. Eastern Niagara: Hire and train patient navigators										

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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 31. Eastern Niagara: Implement program										
Task 32. Millard Fillmore: Identify facility participants										
Task 33. Millard Fillmore: Execute letter of intent or participation agreement (if applicable)										
Task 34. Millard Fillmore: Perform assessment, modify approach for facility										
Task 35. Millard Fillmore: Hire and train patient navigators										
Task 36. Millard Fillmore: Implement program										
Task 37. DeGraff: Identify facility participants										
Task 38. DeGraff: Execute letter of intent or participation agreement (if applicable)										
Task 39. DeGraff: Perform assessment, modify approach for facility										
Task 40. DeGraff: Hire and train patient navigators										
Task 41. DeGraff: Implement program										
Task 42. Lakeshore/TLC: Identify facility participants										
Task 43. Lakeshore/TLC: Execute letter of intent or participation agreement (if applicable)										
Task 44. Lakeshore/TLC: Perform assessment, modify approach for facility										
Task 45. Lakeshore/TLC: Hire and train patient navigators										
Task 46. Lakeshore/TLC: Implement program										
Task 47. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of approach, and allow for continuous improvement over time. Lessons learned will be shared from one implementation to the next.										
Milestone #2 Participating EDs will establish partnerships to community										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	0	126	126
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	10	20	40	70	100	126	126
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	2	4	5	6	7	8	8
Task 1. Develop protocol to provide project roster updates to Chief Reporting Officer (CRO) for update to MCC provider database.										
Task 2. Ensure that CRO has established crosswalks for NCQA and Meaningful Use certification levels in provider database.										
Task 3. Obtain quarterly project roster reporting including provider NCQA and Meaningful Use status from CRO.										
Task 4. Continue to monitor and report status of participating PCPs on a quarterly basis.										
Task 5. Ensure all providers utilize HEALTHeLINK for encounter notifications.										
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.										

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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
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 protocols to direct patient navigators in identifying a PCP and establishing an immediate appointment for patients who do not have a PCP.										
Task 2. Refine protocols for obtaining PCP appointments for patients without a PCP.										
Task 3. Develop protocols to assist patient navigators in identifying needed community support services, depending on patient need.										
Task 4. Refine protocols for identifying needed community support services.										
Task 5. Develop protocols to direct patient navigators in establishing an immediate appointment for patients who have a PCP.										
Task 6. Refine protocols for obtaining PCP appointments for patients who have a PCP.										
Task 7. Create process to export and download encounter information for quarterly reporting.										
Task 8. Deliver first quarterly encounter reporting.										
Task 9. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of approach, and allow for continuous improvement over time										
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	0	0	0	2	4	5	6	7	8	8

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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
patients to appropriate care site. (Optional).										
Task not applicable (optional)										
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. Complete development of Salesforce.com patient encounter/tracking solution.										
Task 2. Obtain MCC licensing and instance for Salesforce.com.										
Task 3. Import encounters tracked in Excel spreadsheet into Salesforce.com.										
Task 4. Manually enter any data missing from manual forms into Salesforce.com.										
Task 5. Port data from UEMS Salesforce.com instance to new MCC license.										
Task 6. Delivery quarterly encounter 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 Establish ED care triage program for at-risk populations										
Task Stand up program based on project requirements										
Task 1. ECMC: Identify facility participants										
Task 2. ECMC: Execute letter of intent/participation agreement										
Task 3. ECMC: Develop implementation approach, training program, tracking and reporting mechanisms										
Task 4. ECMC: Refine processes based on learnings from pilot program										

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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. ECMC: Introduce program and provide training										
Task 6. ECMC: Implement program										
Task 7. NFMMC: Identify facility participants										
Task 8. NFMMC: Execute letter of intent/participation agreement										
Task 9. NFMMC: Perform assessment, modify approach for facility										
Task 10. NFMMC: Hire and train patient navigators										
Task 11. NFMMC: Implement program										
Task 12. Olean and Cuba: Identify facility participants										
Task 13. Olean and Cuba: Execute letter of intent or participation agreement (if applicable)										
Task 14. Olean and Cuba: Perform assessment, modify approach for facility										
Task 15. Olean and Cuba: Hire and train patient navigators										
Task 16. Olean and Cuba: Implement program										
Task 17. Buffalo General Hospital: Identify facility participants										
Task 18. Buffalo General Hospital: Execute letter of intent or participation agreement (if applicable)										
Task 19. Buffalo General Hospital: Perform assessment, modify approach for facility										
Task 20. Buffalo General Hospital: Hire and train patient navigators										
Task 21. Buffalo General Hospital: Implement program										
Task 22. Women's and Children's: Identify facility participants										
Task 23. Women's and Children's: Execute letter of intent or participation agreement (if applicable)										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 24. Women's and Children's: Perform assessment, modify approach for facility										
Task 25. Women's and Children's: Hire and train patient navigators										
Task 26. Women's and Children's: Implement program										
Task 27. Eastern Niagara: Identify facility participants										
Task 28. Eastern Niagara: Execute letter of intent or participation agreement (if applicable)										
Task 29. Eastern Niagara: Perform assessment, modify approach for facility										
Task 30. Eastern Niagara: Hire and train patient navigators										
Task 31. Eastern Niagara: Implement program										
Task 32. Millard Fillmore: Identify facility participants										
Task 33. Millard Fillmore: Execute letter of intent or participation agreement (if applicable)										
Task 34. Millard Fillmore: Perform assessment, modify approach for facility										
Task 35. Millard Fillmore: Hire and train patient navigators										
Task 36. Millard Fillmore: Implement program										
Task 37. DeGraff: Identify facility participants										
Task 38. DeGraff: Execute letter of intent or participation agreement (if applicable)										
Task 39. DeGraff: Perform assessment, modify approach for facility										
Task 40. DeGraff: Hire and train patient navigators										
Task 41. DeGraff: Implement program										
Task 42. Lakeshore/TLC: Identify facility participants										

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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 43. Lakeshore/TLC: Execute letter of intent or participation agreement (if applicable)										
Task 44. Lakeshore/TLC: Perform assessment, modify approach for facility										
Task 45. Lakeshore/TLC: Hire and train patient navigators										
Task 46. Lakeshore/TLC: Implement program										
Task 47. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of approach, and allow for continuous improvement over time. Lessons learned will be shared from one implementation to the next.										
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.	126	126	126	126	126	126	126	126	126	126
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	126	126	126	126	126	126	126	126	126	126
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	8	8	8	8	8	8	8	8	8	8
Task 1. Develop protocol to provide project roster updates to Chief Reporting Officer (CRO) for update to MCC provider database.										
Task 2. Ensure that CRO has established crosswalks for NCQA 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
Meaningful Use certification levels in provider database.										
Task 3. Obtain quarterly project roster reporting including provider NCQA and Meaningful Use status from CRO.										
Task 4. Continue to monitor and report status of participating PCPs on a quarterly basis.										
Task 5. Ensure all providers utilize HEALTHeLINK for encounter notifications.										
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 protocols to direct patient navigators in identifying a PCP and establishing an immediate appointment for patients who do not have a PCP.										
Task 2. Refine protocols for obtaining PCP appointments for patients without a PCP.										
Task 3. Develop protocols to assist patient navigators in identifying needed community support services, depending on patient need.										
Task 4. Refine protocols for identifying needed community support services.										
Task 5. Develop protocols to direct patient navigators in establishing an immediate appointment for patients who have a PCP.										
Task 6. Refine protocols for obtaining PCP appointments for patients										

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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
who have a PCP.										
Task 7. Create process to export and download encounter information for quarterly reporting.										
Task 8. Deliver first quarterly encounter reporting.										
Task 9. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of approach, and allow for continuous improvement over time										
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).	8	8	8	8	8	8	8	8	8	8
Task not applicable (optional)										
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. Complete development of Salesforce.com patient encounter/tracking solution.										
Task 2. Obtain MCC licensing and instance for Salesforce.com.										
Task 3. Import encounters tracked in Excel spreadsheet into Salesforce.com.										
Task 4. Manually enter any data missing from manual forms into Salesforce.com.										
Task 5. Port data from UEMS Salesforce.com instance to new MCC license.										
Task 6. Delivery quarterly encounter reporting.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Establish ED care triage program for at-risk populations	Tasks #1-16 were completed; the timelines for #13-15 were adjusted without impacting other tasks. Other in-progress tasks are on schedule.
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	Tasks #1-3 were completed; the timeline for task #2 was adjusted without impacting other tasks.
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).	Tasks #1-8 were completed on schedule, and in-progress tasks are on schedule.
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.)	not applicable (optional)
Use EHRs and other technical platforms to track all patients engaged in the project.	Tasks #1- 5 were completed; timelines for tasks 2 and 5 were adjusted without impacting other tasks. Other in-progress tasks are on schedule.

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 2.b.vii – Implementing the INTERACT project (inpatient transfer avoidance program for SNF)

IPQR Module 2.b.vii.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.

INTERACT relies on care coordination of patients across varying levels of care which is currently not always effective. Coordination is often impeded by lack of care coordination technology, varied EHR capabilities, and difficulties relaying data to a centralized system. Ensure protocols for care transition are clearly defined. Invest in care coordination technology and train staff to coordinate patient transitions among various levels of care; tie care coordination technology into EHR systems and the RHIO to improve current connectivity standards. Negotiate a group purchasing rate with EHR provider to receive most competitive price for providers. Ensure that information transfer includes patient EHR data which is shared among all stakeholders.

Lack of viable discharge locations for severely ill community-dwelling individuals due to lack of resources and support. Engage CBOs in project. Work through the CBO Task Force to connect patients to community health workers who can get the patients set up for appropriate care outside the SNF/hospital.

Lack of payer reimbursement for activation of INTERACT; potential for a decrease in reimbursement to SNF facilities as a result of not activating skilled services which is currently required; increased SNF costs due to higher levels of acuity among SNF residents. Continue to engage third-party payers to activate a higher level of reimbursement for treating in place vs. sending a patient to the hospital. Evaluate shared savings and bundled payment value-based performance models.

NYS DOH survey exposure related to not sending patients to ED; increase in SNF liability due to higher levels of SNF resident acuity. MCC has submitted appropriate regulatory waivers to help mitigate some of this risk. Staff from the Nursing Home Division of the Western Regional Office of the NYS DOH will be engaged to review potential impact on survey process and impact on resident-related care that could result.

Lack of buy-in from medical directorships and resident families. Some providers may resist INTERACT protocols. Inconsistent adoption will impact MCC's ability to provide effective care, negatively impacting DSRIP metrics. Encourage physicians to participate in policy planning. Offer INTERACT educational seminars to physicians and families to make them more comfortable with the process. Train INTERACT champions to provide additional support for providers who are particularly resistant. Provide opportunities for providers to engage in discussion about the implementation of INTERACT at their facilities. Increase level of expertise of facility practitioners with other interventions such as telemedicine.

There is considerable county overlap with two adjacent PPSs in WNY, so hand-offs from one provider to another may cross PPS "lines." Provide a relatively uniform experience for patients regardless of where they receive care. Patient choice and patient satisfaction must remain a high priority. If a patient is handed off to a provider outside the PPS, ideally the patient would not even need to be aware of this crossover. To create a seamless transition for patients, PPSs will agree to share registry information, use standardized referral protocols, utilize uniform tracking and reporting systems, and maintain common messaging to educate patients.

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INTERACT project consumes a disproportionate amount of limited staff resources which are not reimbursed by payers. PPS formulating plan to provide incentive payments to INTERACT participants and to provide direct payments to offset initial costs of retraining staff. Hire and train a centralized PPS coaching team to assist with providing continued training to all SNF partners after initial partner education has been completed. Organize periodic ongoing in-service training for all staff of participating facilities.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	575

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
158	496	165.33%	-196	86.26%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ethelen	Baseline or Performance Documentation	48_PMDL3215_1_3_20160202171752_2bvii_PE_registry_DY1Q3.xlsx	Patient engagement registry showing 338 patients	02/02/2016 05:18 PM

Narrative Text :

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

patients previously reported in DY1 Q2: 158. new patients engaged in DY1 Q3: 338. cumulative total: 496

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Project	N/A	In Progress	05/28/2015	09/30/2016	05/28/2015	09/30/2016	09/30/2016	DY2 Q2
Task INTERACT principles implemented at each participating SNF.	Project		In Progress	05/28/2015	09/30/2016	05/28/2015	09/30/2016	09/30/2016	DY2 Q2
Task Nursing home to hospital transfers reduced.	Provider	Nursing Home	In Progress	05/28/2015	09/30/2016	05/28/2015	09/30/2016	09/30/2016	DY2 Q2
Task INTERACT 3.0 Toolkit used at each SNF.	Provider	Nursing Home	In Progress	05/28/2015	09/30/2016	05/28/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Develop training plan/requirements for INTERACT training	Project		Completed	05/28/2015	07/17/2015	05/28/2015	07/17/2015	09/30/2015	DY1 Q2
Task 2. Contact vendor about conducting INTERACT training	Project		Completed	05/28/2015	05/28/2015	05/28/2015	05/28/2015	06/30/2015	DY1 Q1
Task 3. Obtain a contract with vendor	Project		Completed	05/28/2015	05/28/2015	05/28/2015	05/28/2015	06/30/2015	DY1 Q1
Task 4. Develop training material	Project		Completed	07/08/2015	07/08/2015	07/08/2015	07/08/2015	09/30/2015	DY1 Q2
Task 5. Vendor contract signed	Project		Completed	05/28/2015	05/28/2015	05/28/2015	05/28/2015	06/30/2015	DY1 Q1
Task 6. Identify training participants	Project		Completed	07/27/2015	07/31/2015	07/27/2015	07/31/2015	09/30/2015	DY1 Q2
Task 7. Develop communication for participants to be informed of training	Project		Completed	06/29/2015	06/30/2015	06/29/2015	06/30/2015	06/30/2015	DY1 Q1
Task 8. Secure training locations	Project		Completed	07/06/2015	07/24/2015	07/06/2015	07/24/2015	09/30/2015	DY1 Q2
Task 9. Schedule training	Project		Completed	07/07/2015	07/15/2015	07/07/2015	07/15/2015	09/30/2015	DY1 Q2
Task 10. Conduct training	Project		Completed	08/17/2015	08/21/2015	08/17/2015	08/21/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 11. Development of SNF direct care educational materials regarding INTERACT principles	Project		Completed	08/24/2015	08/28/2015	08/24/2015	08/28/2015	09/30/2015	DY1 Q2
Task 12. INTERACT PM and coach provide facility INTERACT in-service to direct care staff following I-TEAM training	Project		In Progress	08/31/2015	03/31/2016	08/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task 13. Direct Care Staff complete written test/assessment of INTERACT tools and process knowledge upon completion of in-service	Project		On Hold	08/31/2015	03/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 14. Evaluation tool is created to assess facility implementation of INTERACT protocol and to identify areas of improvement	Project		Completed	08/24/2015	09/30/2016	08/24/2015	12/31/2015	12/31/2015	DY1 Q3
Task 15. INTERACT coach and PM perform quarterly evaluations of each facility and use of INTERACT tools and protocol	Project		In Progress	11/30/2015	09/30/2016	11/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 16. SNF MD/PA/NP education developed regarding INTERACT protocol and process	Project		In Progress	08/24/2015	09/30/2016	08/24/2015	09/30/2016	09/30/2016	DY2 Q2
Task 17. SNF MD/PA/NP education provided regarding INTERACT protocol and process	Project		In Progress	08/31/2015	03/31/2016	08/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task 18. Develop recording template in Excel for data collection of each SNF metrics	Project		Completed	08/24/2015	08/28/2015	08/24/2015	08/28/2015	09/30/2015	DY1 Q2
Task 19. INTERACT coach records transfer data at each quarterly SNF visit	Project		In Progress	08/31/2015	09/30/2016	08/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task 20. Quarterly summary report created compiling results of each facility separately and collectively to analyze effectiveness of program	Project		In Progress	11/30/2015	09/30/2016	11/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 21. Facility needs assessment created to determine EMR/hardware/software capabilities and potential IT/operational barriers	Project		Completed	08/10/2015	08/21/2015	08/10/2015	08/21/2015	09/30/2015	DY1 Q2
Task 22. Facility needs assessment completed by each facility and reviewed by PM	Project		In Progress	08/24/2015	03/31/2016	08/24/2015	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 23. Implementation plan for INTERACT toolkit integration created	Project		Completed	07/23/2015	08/31/2015	07/23/2015	08/31/2015	09/30/2015	DY1 Q2
Task 24. Develop recording measure for SNF staff to use when referencing INTERACT Toolkit	Project		Completed	08/24/2015	08/28/2015	08/24/2015	08/28/2015	09/30/2015	DY1 Q2
Task 25. INTERACT PM and coach to educate necessary SNF staff regarding use of recording measure	Project		In Progress	08/31/2015	03/31/2016	08/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task 26. INTERACT coach and PM to create Toolkit Sharing System for each facility	Project		In Progress	08/24/2015	09/30/2016	08/24/2015	09/30/2016	09/30/2016	DY2 Q2
Task 27. INTERACT coach and PM to distribute Toolkit Sharing System and educate necessary SNF staff in use at each facility	Project		In Progress	08/31/2015	03/31/2016	08/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task 28. INTERACT coach records Toolkit usage data at each quarterly visit	Project		On Hold	11/30/2015	09/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Project	N/A	In Progress	08/03/2015	03/17/2017	08/03/2015	03/17/2017	03/31/2017	DY2 Q4
Task Facility champion identified for each SNF.	Provider	Nursing Home	In Progress	08/03/2015	03/17/2017	08/03/2015	03/17/2017	03/31/2017	DY2 Q4
Task 1. Facility champion description to be developed and distributed to SNFs	Project		Completed	08/03/2015	08/07/2015	08/03/2015	08/07/2015	09/30/2015	DY1 Q2
Task 2. Each SNF to select facility champion	Project		In Progress	08/10/2015	03/17/2017	08/10/2015	03/17/2017	03/31/2017	DY2 Q4
Task 3. Facility champion to sign participation contract	Project		On Hold	08/10/2015	03/17/2017	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 4. Record facility champion name and contact information into master list	Project		In Progress	08/10/2015	03/17/2017	08/10/2015	03/17/2017	03/31/2017	DY2 Q4
Task 5. Arrange meeting opportunities for facility champions to meet and discuss implementation successes and barriers, share lessons learned.	Project		In Progress	08/27/2015	03/17/2017	08/27/2015	03/17/2017	03/31/2017	DY2 Q4
Milestone #3 Implement care pathways and other clinical tools for monitoring	Project	N/A	In Progress	08/10/2015	03/31/2017	08/10/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.									
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Project		In Progress	08/10/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Project		In Progress	08/10/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Collaborate with SNFs to analyze INTERACT Care Pathway materials and develop reference materials for each facility	Project		In Progress	08/17/2015	09/30/2016	08/17/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Develop recording measure for SNF staff to use when referencing INTERACT Care pathways and Tools	Project		On Hold	08/24/2015	09/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 3. INTERACT Coach and PM to create Care pathway sharing system for use while providing direct patient care	Project		In Progress	08/24/2015	09/30/2016	08/24/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. INTERACT Coach and PM to distribute Care pathway reference materials and sharing system to each SNF	Project		In Progress	11/02/2015	03/31/2016	11/02/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5. INTERACT coach records Care pathway usage data at each quarterly visit	Project		In Progress	11/02/2015	03/31/2017	11/02/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Facility participation in ITEAM training	Project		Completed	08/17/2015	08/21/2015	08/17/2015	08/21/2015	09/30/2015	DY1 Q2
Task 7. Facility identification of Nurse Champion	Project		In Progress	08/10/2015	03/17/2017	10/01/2015	03/17/2017	03/31/2017	DY2 Q4
Task 8. Collaboration with each SNF Nurse Champion and other necessary staff to strategize effective course of action to monitor critically ill patients	Project		In Progress	08/24/2015	03/31/2017	08/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 9. Development of implementation plan created for hospital avoidance and chronic condition monitoring	Project		In Progress	08/27/2015	03/31/2017	08/27/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Educational materials created for direct care staff in-service on hospital avoidance and chronic condition monitoring plan	Project		In Progress	08/27/2015	03/31/2017	08/27/2015	03/31/2017	03/31/2017	DY2 Q4

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Millennium Collaborative Care (PPS ID:48)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 11. Education provided to facility direct care staff regarding hospital avoidance and chronic condition monitoring plan and process	Project		In Progress	08/31/2015	09/30/2016	08/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task 12. Quarterly evaluations of SNF implementation of hospital avoidance and chronic condition monitoring plan	Project		In Progress	11/02/2015	03/31/2017	11/02/2015	03/31/2017	03/31/2017	DY2 Q4
Task 13. Quarterly report written documenting progress and impediments to program	Project		In Progress	11/02/2015	03/31/2017	11/02/2015	03/31/2017	03/31/2017	DY2 Q4
Task 14. As needed consultations with PM at each SNF regarding areas of weakness in program implementation	Project		In Progress	11/02/2015	03/31/2017	11/02/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Educate all staff on care pathways and INTERACT principles.	Project	N/A	In Progress	08/24/2015	09/30/2016	08/24/2015	09/30/2016	09/30/2016	DY2 Q2
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	Provider	Nursing Home	In Progress	08/24/2015	09/30/2016	08/24/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Facility direct care staff care pathway and INTERACT principle in-service is created	Project		Completed	08/24/2015	09/30/2016	08/24/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. INTERACT PM to develop training material regarding INTERACT toolkit and Care pathways to be included in each facility's orientation materials for new employees	Project		In Progress	08/24/2015	09/30/2016	08/24/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. INTERACT Coach and PM to provide education to direct care staff of each facility regarding Care pathways and use in everyday practice	Project		In Progress	08/31/2015	09/30/2016	08/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. INTERACT Coach and PM to provide education to direct care staff of each facility regarding Toolkit and use in everyday practice	Project		In Progress	08/31/2015	09/30/2016	08/31/2015	09/30/2016	09/30/2016	DY2 Q2
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Project	N/A	In Progress	07/22/2015	03/31/2017	07/22/2015	03/31/2017	03/31/2017	DY2 Q4
Task Advance Care Planning tools incorporated into program (as	Project		In Progress	07/22/2015	03/31/2017	07/22/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
evidenced by policies and procedures).									
Task 1. Form Palliative Care Committee to identify gaps in Advance Care Planning Process and formulate policy for Advance Care Planning Procedure	Project		Completed	07/22/2015	11/23/2015	07/22/2015	11/23/2015	12/31/2015	DY1 Q3
Task 2. Collaborate with other palliative care resources within community (e.g., The Conversation Project, Hospice Buffalo) to identify areas of overlap and/or barriers to progress	Project		Completed	07/27/2015	11/23/2015	07/27/2015	11/23/2015	12/31/2015	DY1 Q3
Task 3. Advance care planning toolkit developed by PM using INTERACT tools and other palliative/geriatric care resources as reference (The Conversation Project, The Coalition for Compassionate Care, Closure.org, Caring Connections of the National Hospice Org)	Project		In Progress	07/22/2015	01/31/2016	07/22/2015	01/31/2016	03/31/2016	DY1 Q4
Task 4. Advance care planning toolkit distributed to SNFs	Project		Not Started	02/01/2016	04/30/2016	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Social work and other applicable direct care staff educated on Advance care planning toolkit by either PM or INTERACT coach	Project		Not Started	02/01/2016	04/30/2016	02/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Develop recording measure for SNF staff to use when referencing Advanced Care Planning Tools	Project		On Hold	07/27/2015	01/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 7. Educate necessary SNF staff regarding use of Advance Care Planning recording measure	Project		Not Started	02/01/2016	04/30/2016	02/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task 8. INTERACT coach and PM to record Advance Care Planning metrics quarterly	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Measure effectiveness of Advance Care Planning tool and adjust as needed based on results	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Create coaching program to facilitate and support implementation.	Project	N/A	In Progress	07/06/2015	03/31/2017	07/06/2015	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT coaching program established at each SNF.	Provider	Nursing Home	In Progress	07/06/2015	03/31/2017	07/06/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. INTERACT Coach Job description written	Project		Completed	07/06/2015	07/06/2015	07/06/2015	07/06/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 2. INTERACT Coach position(s) approved	Project		Completed	07/17/2015	07/17/2015	07/17/2015	07/17/2015	09/30/2015	DY1 Q2
Task 3. INTERACT Coach position(s) posted	Project		Completed	07/29/2015	08/21/2015	07/29/2015	08/21/2015	09/30/2015	DY1 Q2
Task 4. INTERACT Coach position(s) candidates interviewed	Project		Completed	08/03/2015	08/21/2015	08/03/2015	08/21/2015	09/30/2015	DY1 Q2
Task 5. INTERACT Coach position(s) hired	Project		Completed	08/24/2015	09/30/2015	08/24/2015	09/30/2015	09/30/2015	DY1 Q2
Task 6. PM creates schedule for SNF training and quarterly visits to each facility	Project		Completed	08/24/2015	09/30/2015	08/24/2015	09/30/2015	09/30/2015	DY1 Q2
Task 7. INTERACT Coach and PM collaborate with each SNF to provide initial INTERACT training to direct care staff	Project		In Progress	08/31/2015	09/30/2016	08/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8. INTERACT Coach and PM perform quarterly visits to each SNF for data gathering and on site training when required	Project		In Progress	11/30/2015	03/31/2017	11/30/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Project	N/A	Not Started	01/04/2016	04/29/2016	01/04/2016	03/31/2017	03/31/2017	DY2 Q4
Task Patients and families educated and involved in planning of care using INTERACT principles.	Project		Not Started	01/04/2016	04/29/2016	01/04/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Collaborate with community providers regarding current state processes and engagement of family and resident in planning of care; review resources and educational materials available	Project		Not Started	01/04/2016	01/15/2016	01/04/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Collaborate with "Voice of the Consumer" sub-committee to ensure cultural competence within educational materials and program	Project		Not Started	01/04/2016	03/31/2016	01/04/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Create informational resources for resident and family regarding advance care planning and hospital avoidance, benefits to patient remaining in house	Project		Not Started	01/18/2016	03/31/2016	01/18/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Educate Social Work and other applicable direct care staff on resident/family education and informational resource hand off to resident/family	Project		Not Started	01/25/2016	04/29/2016	01/25/2016	03/31/2017	03/31/2017	DY2 Q4

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Task 5. Create documentation tool for staff to record when family education using provided tools has been completed	Project		Not Started	01/18/2016	03/31/2016	01/18/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Educate staff in use of documentation tool for data recording	Project		Not Started	01/25/2016	04/29/2016	01/25/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Project	N/A	In Progress	06/30/2015	09/30/2016	06/30/2015	09/30/2016	09/30/2016	DY2 Q2
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	06/30/2015	09/30/2016	06/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	06/30/2015	09/30/2016	06/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Nursing Home	In Progress	06/30/2015	09/30/2016	06/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Collaborate with community providers to define SNF business requirements for EHR	Project		In Progress	08/24/2015	09/30/2016	08/24/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Share requirements with 2ai IDS project	Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Collaborate with DSRIP project 2ai to understand capabilities	Project		In Progress	06/30/2015	09/30/2016	06/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Develop a plan for implementation across SNFs	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 5. Execute the implementation plan	Project		Not Started	04/11/2016	09/30/2016	04/11/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Project	N/A	In Progress	07/30/2015	09/30/2016	07/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Project		In Progress	07/30/2015	09/30/2016	07/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task Quality committee identifies opportunities for quality improvement and use of rapid cycle improvement	Project		In Progress	07/30/2015	09/30/2016	07/30/2015	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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 in Attachment J.	Project		In Progress	07/30/2015	09/30/2016	07/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task Service and quality outcome measures are reported to all stakeholders.	Project		In Progress	07/30/2015	09/30/2016	07/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Create quality committee for INTERACT project.	Project		Completed	07/30/2015	09/10/2015	07/30/2015	09/10/2015	09/30/2015	DY1 Q2
Task 2. Schedule quarterly INTERACT quality committee meetings.	Project		In Progress	08/06/2015	09/30/2016	08/06/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Create presentation of quarterly metrics and statistics from aggregated data collected at quarterly SNF contact and site visits	Project		In Progress	11/30/2015	09/30/2016	11/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Present findings to INTERACT quality committee, discuss problem areas, areas of success that could be applied to other facilities.	Project		In Progress	11/30/2015	09/30/2016	11/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Create quarterly improvement plans based on quarterly program outcomes from each SNF. INTERACT quality committee will provide quarterly reports to the MCC Clinical/Quality Committee.	Project		In Progress	11/30/2015	09/30/2016	11/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6. Schedule trainings with applicable SNFs who require implementation of improvement plans.	Project		In Progress	11/30/2015	09/30/2016	11/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 7. Hold improvement trainings at each applicable SNF with direct care staff.	Project		In Progress	12/07/2015	09/30/2016	12/07/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8. Administer facility evaluation one month post improvement training to analyze success of remediation.	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 9. Distribute improvement plans to members of quality committee via email or MCC website.	Project		In Progress	12/07/2015	09/30/2016	12/07/2015	09/30/2016	09/30/2016	DY2 Q2
Task 10. Distribute results of improvement plan implementation within	Project		Not Started	01/07/2016	09/30/2016	01/07/2016	09/30/2016	09/30/2016	DY2 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
facilities and lessons learned via email or MCC website.									
Milestone #10 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	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	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Define patient tracking requirements and metrics for enterprise DSRIP solution.	Project		In Progress	10/05/2015	01/29/2016	10/05/2015	01/29/2016	03/31/2016	DY1 Q4
Task 2. Share requirements with 2ai IDS project.	Project		In Progress	10/02/2015	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Collaborate with DSRIP project 2ai to understand capabilities.	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Develop a plan for implementation across SNFs.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Execute the implementation plan.	Project		Not Started	08/01/2016	03/31/2017	08/01/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	0	3	10	25	40	53	53	53	53	53
Task INTERACT 3.0 Toolkit used at each SNF.	0	3	10	25	40	53	53	53	53	53
Task 1. Develop training plan/requirements for INTERACT training										
Task 2. Contact vendor about conducting INTERACT training										
Task 3. Obtain a contract with vendor										
Task 4. Develop training material										
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
5. Vendor contract signed										
Task 6. Identify training participants										
Task 7. Develop communication for participants to be informed of training										
Task 8. Secure training locations										
Task 9. Schedule training										
Task 10. Conduct training										
Task 11. Development of SNF direct care educational materials regarding INTERACT principles										
Task 12. INTERACT PM and coach provide facility INTERACT in-service to direct care staff following I-TEAM training										
Task 13. Direct Care Staff complete written test/assessment of INTERACT tools and process knowledge upon completion of in-service										
Task 14. Evaluation tool is created to assess facility implementation of INTERACT protocol and to identify areas of improvement										
Task 15. INTERACT coach and PM perform quarterly evaluations of each facility and use of INTERACT tools and protocol										
Task 16. SNF MD/PA/NP education developed regarding INTERACT protocol and process										
Task 17. SNF MD/PA/NP education provided regarding INTERACT protocol and process										
Task 18. Develop recording template in Excel for data collection of each SNF metrics										
Task 19. INTERACT coach records transfer data at each quarterly SNF visit										
Task 20. Quarterly summary report created compiling results of each facility separately and collectively to analyze effectiveness of program										

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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 21. Facility needs assessment created to determine EMR/hardware/software capabilities and potential IT/operational barriers										
Task 22. Facility needs assessment completed by each facility and reviewed by PM										
Task 23. Implementation plan for INTERACT toolkit integration created										
Task 24. Develop recording measure for SNF staff to use when referencing INTERACT Toolkit										
Task 25. INTERACT PM and coach to educate necessary SNF staff regarding use of recording measure										
Task 26. INTERACT coach and PM to create Toolkit Sharing System for each facility										
Task 27. INTERACT coach and PM to distribute Toolkit Sharing System and educate necessary SNF staff in use at each facility										
Task 28. INTERACT coach records Toolkit usage data at each quarterly visit										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										
Task Facility champion identified for each SNF.	0	3	10	25	40	53	53	53	53	53
Task 1. Facility champion description to be developed and distributed to SNFs										
Task 2. Each SNF to select facility champion										
Task 3. Facility champion to sign participation contract										
Task 4. Record facility champion name and contact information into master list										
Task 5. Arrange meeting opportunities for facility champions to meet and discuss implementation successes and barriers, share lessons learned.										
Milestone #3										

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Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task 1. Collaborate with SNFs to analyze INTERACT Care Pathway materials and develop reference materials for each facility										
Task 2. Develop recording measure for SNF staff to use when referencing INTERACT Care pathways and Tools										
Task 3. INTERACT Coach and PM to create Care pathway sharing system for use while providing direct patient care										
Task 4. INTERACT Coach and PM to distribute Care pathway reference materials and sharing system to each SNF										
Task 5. INTERACT coach records Care pathway usage data at each quarterly visit										
Task 6. Facility participation in ITEAM training										
Task 7. Facility identification of Nurse Champion										
Task 8. Collaboration with each SNF Nurse Champion and other necessary staff to strategize effective course of action to monitor critically ill patients										
Task 9. Development of implementation plan created for hospital avoidance and chronic condition monitoring										
Task 10. Educational materials created for direct care staff in-service on hospital avoidance and chronic condition monitoring plan										
Task 11. Education provided to facility direct care staff regarding hospital avoidance and chronic condition monitoring plan and process										

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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 12. Quarterly evaluations of SNF implementation of hospital avoidance and chronic condition monitoring plan										
Task 13. Quarterly report written documenting progress and impediments to program										
Task 14. As needed consultations with PM at each SNF regarding areas of weakness in program implementation										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	0	3	10	25	40	53	53	53	53	53
Task 1. Facility direct care staff care pathway and INTERACT principle in-service is created										
Task 2. INTERACT PM to develop training material regarding INTERACT toolkit and Care pathways to be included in each facility's orientation materials for new employees										
Task 3. INTERACT Coach and PM to provide education to direct care staff of each facility regarding Care pathways and use in everyday practice										
Task 4. INTERACT Coach and PM to provide education to direct care staff of each facility regarding Toolkit and use in everyday practice										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task 1. Form Palliative Care Committee to identify gaps in Advance Care Planning Process and formulate policy for Advance Care Planning Procedure										
Task 2. Collaborate with other palliative care resources within community (e.g., The Conversation Project, Hospice Buffalo) to identify areas of overlap and/or barriers to progress										

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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. Advance care planning toolkit developed by PM using INTERACT tools and other palliative/geriatric care resources as reference (The Conversation Project, The Coalition for Compassionate Care, Closure.org, Caring Connections of the National Hospice Org)										
Task 4. Advance care planning toolkit distributed to SNFs										
Task 5. Social work and other applicable direct care staff educated on Advance care planning toolkit by either PM or INTERACT coach										
Task 6. Develop recording measure for SNF staff to use when referencing Advanced Care Planning Tools										
Task 7. Educate necessary SNF staff regarding use of Advance Care Planning recording measure										
Task 8. INTERACT coach and PM to record Advance Care Planning metrics quarterly										
Task 9. Measure effectiveness of Advance Care Planning tool and adjust as needed based on results										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT coaching program established at each SNF.	0	3	10	25	40	53	53	53	53	53
Task 1. INTERACT Coach Job description written										
Task 2. INTERACT Coach position(s) approved										
Task 3. INTERACT Coach position(s) posted										
Task 4. INTERACT Coach position(s) candidates interviewed										
Task 5. INTERACT Coach position(s) hired										
Task 6. PM creates schedule for SNF training and quarterly visits to each facility										
Task 7. INTERACT Coach and PM collaborate with each SNF to provide initial INTERACT training to direct care staff										

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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 8. INTERACT Coach and PM perform quarterly visits to each SNF for data gathering and on site training when required										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										
Task 1. Collaborate with community providers regarding current state processes and engagement of family and resident in planning of care; review resources and educational materials available										
Task 2. Collaborate with "Voice of the Consumer" sub-committee to ensure cultural competence within educational materials and program										
Task 3. Create informational resources for resident and family regarding advance care planning and hospital avoidance, benefits to patient remaining in house										
Task 4. Educate Social Work and other applicable direct care staff on resident/family education and informational resource hand off to resident/family										
Task 5. Create documentation tool for staff to record when family education using provided tools has been completed										
Task 6. Educate staff in use of documentation tool for data recording										
Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.										
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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	25	25	25	25	25
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	49	49	49	49	49
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
1. Collaborate with community providers to define SNF business requirements for EHR										
Task 2. Share requirements with 2ai IDS project										
Task 3. Collaborate with DSRIP project 2ai to understand capabilities										
Task 4. Develop a plan for implementation across SNFs										
Task 5. Execute the implementation plan										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
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 in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 1. Create quality committee for INTERACT project.										
Task 2. Schedule quarterly INTERACT quality committee meetings.										
Task 3. Create presentation of quarterly metrics and statistics from aggregated data collected at quarterly SNF contact and site visits										
Task 4. Present findings to INTERACT quality committee, discuss problem areas, areas of success that could be applied to other facilities.										
Task 5. Create quarterly improvement plans based on quarterly program outcomes from each SNF. INTERACT quality committee will provide quarterly reports to the MCC Clinical/Quality Committee.										

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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. Schedule trainings with applicable SNFs who require implementation of improvement plans.										
Task 7. Hold improvement trainings at each applicable SNF with direct care staff.										
Task 8. Administer facility evaluation one month post improvement training to analyze success of remediation.										
Task 9. Distribute improvement plans to members of quality committee via email or MCC website.										
Task 10. Distribute results of improvement plan implementation within facilities and lessons learned via email or MCC website.										
Milestone #10 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. Define patient tracking requirements and metrics for enterprise DSRIP solution.										
Task 2. Share requirements with 2ai IDS project.										
Task 3. Collaborate with DSRIP project 2ai to understand capabilities.										
Task 4. Develop a plan for implementation across SNFs.										
Task 5. Execute the implementation plan.										

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 INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.										
Task INTERACT principles implemented at each participating SNF.										
Task Nursing home to hospital transfers reduced.	53	53	53	53	53	53	53	53	53	53

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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 INTERACT 3.0 Toolkit used at each SNF.	53	53	53	53	53	53	53	53	53	53
Task 1. Develop training plan/requirements for INTERACT training										
Task 2. Contact vendor about conducting INTERACT training										
Task 3. Obtain a contract with vendor										
Task 4. Develop training material										
Task 5. Vendor contract signed										
Task 6. Identify training participants										
Task 7. Develop communication for participants to be informed of training										
Task 8. Secure training locations										
Task 9. Schedule training										
Task 10. Conduct training										
Task 11. Development of SNF direct care educational materials regarding INTERACT principles										
Task 12. INTERACT PM and coach provide facility INTERACT in-service to direct care staff following I-TEAM training										
Task 13. Direct Care Staff complete written test/assessment of INTERACT tools and process knowledge upon completion of in-service										
Task 14. Evaluation tool is created to assess facility implementation of INTERACT protocol and to identify areas of improvement										
Task 15. INTERACT coach and PM perform quarterly evaluations of each facility and use of INTERACT tools and protocol										
Task 16. SNF MD/PA/NP education developed regarding INTERACT protocol and process										
Task 17. SNF MD/PA/NP education provided regarding INTERACT										

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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
protocol and process										
Task 18. Develop recording template in Excel for data collection of each SNF metrics										
Task 19. INTERACT coach records transfer data at each quarterly SNF visit										
Task 20. Quarterly summary report created compiling results of each facility separately and collectively to analyze effectiveness of program										
Task 21. Facility needs assessment created to determine EMR/hardware/software capabilities and potential IT/operational barriers										
Task 22. Facility needs assessment completed by each facility and reviewed by PM										
Task 23. Implementation plan for INTERACT toolkit integration created										
Task 24. Develop recording measure for SNF staff to use when referencing INTERACT Toolkit										
Task 25. INTERACT PM and coach to educate necessary SNF staff regarding use of recording measure										
Task 26. INTERACT coach and PM to create Toolkit Sharing System for each facility										
Task 27. INTERACT coach and PM to distribute Toolkit Sharing System and educate necessary SNF staff in use at each facility										
Task 28. INTERACT coach records Toolkit usage data at each quarterly visit										
Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.										
Task Facility champion identified for each SNF.	53	53	53	53	53	53	53	53	53	53
Task 1. Facility champion description to be developed and distributed to SNFs										

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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. Each SNF to select facility champion										
Task 3. Facility champion to sign participation contract										
Task 4. Record facility champion name and contact information into master list										
Task 5. Arrange meeting opportunities for facility champions to meet and discuss implementation successes and barriers, share lessons learned.										
Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.										
Task 1. Collaborate with SNFs to analyze INTERACT Care Pathway materials and develop reference materials for each facility										
Task 2. Develop recording measure for SNF staff to use when referencing INTERACT Care pathways and Tools										
Task 3. INTERACT Coach and PM to create Care pathway sharing system for use while providing direct patient care										
Task 4. INTERACT Coach and PM to distribute Care pathway reference materials and sharing system to each SNF										
Task 5. INTERACT coach records Care pathway usage data at each quarterly visit										
Task 6. Facility participation in ITEAM training										
Task 7. Facility identification of Nurse Champion										
Task 8. Collaboration with each SNF Nurse Champion and other										

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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
necessary staff to strategize effective course of action to monitor critically ill patients										
Task 9. Development of implementation plan created for hospital avoidance and chronic condition monitoring										
Task 10. Educational materials created for direct care staff in-service on hospital avoidance and chronic condition monitoring plan										
Task 11. Education provided to facility direct care staff regarding hospital avoidance and chronic condition monitoring plan and process										
Task 12. Quarterly evaluations of SNF implementation of hospital avoidance and chronic condition monitoring plan										
Task 13. Quarterly report written documenting progress and impediments to program										
Task 14. As needed consultations with PM at each SNF regarding areas of weakness in program implementation										
Milestone #4 Educate all staff on care pathways and INTERACT principles.										
Task Training program for all SNF staff established encompassing care pathways and INTERACT principles.	53	53	53	53	53	53	53	53	53	53
Task 1. Facility direct care staff care pathway and INTERACT principle in-service is created										
Task 2. INTERACT PM to develop training material regarding INTERACT toolkit and Care pathways to be included in each facility's orientation materials for new employees										
Task 3. INTERACT Coach and PM to provide education to direct care staff of each facility regarding Care pathways and use in everyday practice										
Task 4. INTERACT Coach and PM to provide education to direct care staff of each facility regarding Toolkit and use in everyday practice										
Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end										

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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
of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task 1. Form Palliative Care Committee to identify gaps in Advance Care Planning Process and formulate policy for Advance Care Planning Procedure										
Task 2. Collaborate with other palliative care resources within community (e.g., The Conversation Project, Hospice Buffalo) to identify areas of overlap and/or barriers to progress										
Task 3. Advance care planning toolkit developed by PM using INTERACT tools and other palliative/geriatric care resources as reference (The Conversation Project, The Coalition for Compassionate Care, Closure.org, Caring Connections of the National Hospice Org)										
Task 4. Advance care planning toolkit distributed to SNFs										
Task 5. Social work and other applicable direct care staff educated on Advance care planning toolkit by either PM or INTERACT coach										
Task 6. Develop recording measure for SNF staff to use when referencing Advanced Care Planning Tools										
Task 7. Educate necessary SNF staff regarding use of Advance Care Planning recording measure										
Task 8. INTERACT coach and PM to record Advance Care Planning metrics quarterly										
Task 9. Measure effectiveness of Advance Care Planning tool and adjust as needed based on results										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT coaching program established at each SNF.	53	53	53	53	53	53	53	53	53	53
Task 1. INTERACT Coach Job description written										
Task 2. INTERACT Coach position(s) approved										

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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. INTERACT Coach position(s) posted										
Task 4. INTERACT Coach position(s) candidates interviewed										
Task 5. INTERACT Coach position(s) hired										
Task 6. PM creates schedule for SNF training and quarterly visits to each facility										
Task 7. INTERACT Coach and PM collaborate with each SNF to provide initial INTERACT training to direct care staff										
Task 8. INTERACT Coach and PM perform quarterly visits to each SNF for data gathering and on site training when required										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT principles.										
Task 1. Collaborate with community providers regarding current state processes and engagement of family and resident in planning of care; review resources and educational materials available										
Task 2. Collaborate with "Voice of the Consumer" sub-committee to ensure cultural competence within educational materials and program										
Task 3. Create informational resources for resident and family regarding advance care planning and hospital avoidance, benefits to patient remaining in house										
Task 4. Educate Social Work and other applicable direct care staff on resident/family education and informational resource hand off to resident/family										
Task 5. Create documentation tool for staff to record when family education using provided tools has been completed										
Task 6. Educate staff in use of documentation tool for data recording										
Milestone #8 Establish enhanced communication with acute care hospitals,										

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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
preferably with EHR and HIE connectivity.										
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 EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	25	25	25	25	25	25	25	25	25	25
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	49	49	49	49	49	49	49	49	49	49
Task 1. Collaborate with community providers to define SNF business requirements for EHR										
Task 2. Share requirements with 2ai IDS project										
Task 3. Collaborate with DSRIP project 2ai to understand capabilities										
Task 4. Develop a plan for implementation across SNFs										
Task 5. Execute the implementation plan										
Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
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 in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 1. Create quality committee for INTERACT project.										
Task 2. Schedule quarterly INTERACT quality committee meetings.										

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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. Create presentation of quarterly metrics and statistics from aggregated data collected at quarterly SNF contact and site visits										
Task 4. Present findings to INTERACT quality committee, discuss problem areas, areas of success that could be applied to other facilities.										
Task 5. Create quarterly improvement plans based on quarterly program outcomes from each SNF. INTERACT quality committee will provide quarterly reports to the MCC Clinical/Quality Committee.										
Task 6. Schedule trainings with applicable SNFs who require implementation of improvement plans.										
Task 7. Hold improvement trainings at each applicable SNF with direct care staff.										
Task 8. Administer facility evaluation one month post improvement training to analyze success of remediation.										
Task 9. Distribute improvement plans to members of quality committee via email or MCC website.										
Task 10. Distribute results of improvement plan implementation within facilities and lessons learned via email or MCC website.										
Milestone #10 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. Define patient tracking requirements and metrics for enterprise DSRIP solution.										
Task 2. Share requirements with 2ai IDS project.										
Task 3. Collaborate with DSRIP project 2ai to understand capabilities.										
Task 4. Develop a plan for implementation across SNFs.										
Task 5. Execute the implementation plan.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	In-progress tasks are progressing as expected. The Implementation Survey/Needs Assessment has been sent multiple times to all SNF facilities. We have received 35 out of 52 surveys/assessments back. It is taking extended time to outreach to facilities who have yet to respond. Tasks #13 and 28 were determined to be unnecessary.
Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	We completed task #1 in this milestone and the remaining tasks are progressing as expected. Task #3 was determined to be unnecessary.
Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	All scheduled tasks have been initiated and are progressing as anticipated. Task #6 has been completed. Task #2 was determined to be unnecessary.
Educate all staff on care pathways and INTERACT principles.	All scheduled tasks have been initiated and are progressing as anticipated.
Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	All scheduled tasks have been initiated and are progressing as anticipated. Task #6 was determined to be unnecessary.
Create coaching program to facilitate and support implementation.	We have completed tasks #1-6 in this milestone and the remaining tasks are progressing as expected.
Educate patient and family/caretakers, to facilitate participation in planning of care.	The end date for this milestone had been incorrectly entered previously. The end date was changed to correct this error.
Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	All scheduled tasks have been initiated and are progressing as anticipated. Task #1 was incorporated into the Implementation Survey/Needs Assessment task and therefore has been started early.
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	We have completed task #1 in this milestone and the remaining tasks are progressing as expected.
Use EHRs and other technical platforms to track all patients engaged in the project.	All scheduled tasks have been initiated and are progressing as anticipated.

Milestone Review Status

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #4	Pass & Ongoing	
Milestone #5	Pass & Ongoing	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 2.b.viii – Hospital-Home Care Collaboration Solutions

IPQR Module 2.b.viii.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.

In order for a patient who presents to an emergency department (ED) to safely transition back into the community and avoid a hospital admission, a physician-ordered plan of care needs to be established. ED/hospital physicians may be reluctant to sign orders to initiate the community-based plan of care for patients without a PCP. Link patients to a PCP who will assume responsibility of managing patient collaboratively with community-based resources. Educate ED/hospital physicians regarding their temporary role of initiating orders and care management until patient is linked with a PCP. Identify need for PCP linkage at ED intake. Develop a centralized PCP group that is available on short notice to see patient, sign orders, and manage case.

Changing the ED utilization culture will be challenging. ED physicians do not feel confident that redirecting patient to a community-based plan of care will be safe or effective. Conduct outreach and advertising in the community to educate on the alternatives to ED visits. Educate ED/hospital physicians and staff on capabilities of community providers. Communicate expected timeliness to initiate treatment. Describe expectations for follow-up and ongoing communication between the provider and the physician.

Lack of a multidisciplinary hospital admission avoidance process. Develop a rapid response team that coordinates many organizations across the continuum of care. Initiates the process that triages patient and implements a plan of care to safely address the needs in the home to avoid an unnecessary hospitalization.

Insurance considerations become an operational challenge due to the time-of-day and urgency of delivering skilled services; insurances may not be readily accessible to grant prior authorization for the ordered services, which could lead to financial liability for the patient and providers. Work with payers to develop reimbursement authorization procedures and drug coverage protocols that will ensure the best possible outcomes for stakeholders.

Medications and medical equipment may not be dispensed soon enough to accommodate a change in treatment plan for the home care patient. Establish procedures that address "first-dose" accommodations at the facility where the patient presents. This will allow for adequate preparation of complex services that will be subsequently provided in the patient's home. Work with payers to develop protocols for medication/DME authorization.

Patients residing in rural areas have difficulty accessing their PCPs; due to lack of periodic monitoring and medical intervention of chronic conditions, rural patients may be prone to utilize the ED. Establish/access a "mobile physician" group to perform medical assessment in the home. Educate physicians on how and when to link the patient with a home care agency. Utilize tele-monitoring programs to remotely allow for patient/provider interaction. Establish regional triage satellites.

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The high volume of patients with behavioral health needs in the WNY region require a more specialized approach. Develop behavioral health home care teams. Coordinate services and orders between the patient's psychiatrist and PCP. Increase communication among behavioral health clinics, the health home, and home care teams.

Grand scale implementation of this project can lead to failure and a loss of confidence in the home care/hospital collaboration process. Maintain consistent performance throughout the project to gain buy-in and communicate that the initiatives are safe, efficient, and patient-centric. Roll out the project in well-defined steps. Evaluate the processes' effectiveness regularly. Encourage participation from multiple providers.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	1,125

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
339	339	127.92%	-74	30.13%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ethelen	Other	48_PMDL3315_1_3_20160202185332_null.pdf	No patient engagement is being reported for Q3	02/02/2016 06:55 PM

Narrative Text :

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

Annual patient engagement target has already been met.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Project	N/A	In Progress	07/06/2015	09/30/2016	07/06/2015	09/30/2016	09/30/2016	DY2 Q2
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services	Project		In Progress	07/06/2015	09/30/2016	07/06/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Develop RRT model with collaboration from community providers (ED staff, HHAs, health homes).	Project		Completed	07/06/2015	12/31/2015	07/06/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Coordinate Hospital Avoidance Pilot Program training date for NFMMC ED staff.	Project		Completed	08/03/2015	10/12/2015	08/03/2015	10/12/2015	12/31/2015	DY1 Q3
Task 3. Secure venue for NFMMC Pilot Program training.	Project		Completed	08/03/2015	10/19/2015	08/03/2015	10/19/2015	12/31/2015	DY1 Q3
Task 4. Identify NFMMC training participants.	Project		Completed	08/03/2015	10/19/2015	08/03/2015	10/19/2015	12/31/2015	DY1 Q3
Task 5. Create NFMMC invitation/communication for training.	Project		Completed	08/03/2015	10/19/2015	08/03/2015	10/19/2015	12/31/2015	DY1 Q3
Task 6. Develop NFMMC presentation and training materials.	Project		Completed	08/03/2015	10/19/2015	08/03/2015	10/19/2015	12/31/2015	DY1 Q3
Task 7. Train NFMMC ED staff using presentation for Pilot Program.	Project		Completed	08/24/2015	10/19/2015	08/24/2015	10/19/2015	12/31/2015	DY1 Q3
Task 8. Develop metric recording and program procedure documents for NFMMC pilot.	Project		Completed	08/03/2015	12/31/2015	08/03/2015	12/31/2015	12/31/2015	DY1 Q3
Task 9. Train NFMMC ED staff on data collection for Pilot Program.	Project		Completed	08/24/2015	10/12/2015	08/24/2015	10/12/2015	12/31/2015	DY1 Q3

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Task 10. Launch NFMMC Pilot Program.	Project		Completed	08/31/2015	12/31/2015	08/31/2015	12/31/2015	12/31/2015	DY1 Q3
Task 11. Hold weekly meetings to collect metrics and discuss barriers.	Project		Completed	09/07/2015	12/31/2015	09/07/2015	12/31/2015	12/31/2015	DY1 Q3
Task 12. Solidify process and procedure documents for NFMMC pilot.	Project		Completed	09/07/2015	12/31/2015	09/07/2015	12/31/2015	12/31/2015	DY1 Q3
Task 13. Summarize findings from NFMMC Pilot Program and/or lessons learned from pilot programs.	Project		Completed	11/30/2015	12/31/2015	11/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task 14. Develop RRT model based on lessons learned from pilot programs.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 15. Implement RRT model at remaining hospitals.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	Project	N/A	In Progress	05/28/2015	03/31/2017	05/28/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	Provider	Home Care Facilities	In Progress	05/28/2015	03/31/2017	05/28/2015	03/31/2017	03/31/2017	DY2 Q4
Task Evidence-based guidelines for chronic-condition management implemented.	Project		In Progress	05/28/2015	03/31/2017	05/28/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop training plan/requirements for Home Health specific I-TEAM training.	Project		Completed	07/20/2015	09/30/2015	07/20/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Collaborate with Project 2bvii to obtain a contract with INTERACT training vendor.	Project		Completed	05/28/2015	09/30/2015	05/28/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Develop Home Health specific INTERACT training material.	Project		Completed	08/17/2015	09/30/2015	08/17/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Identify training participants.	Project		Completed	07/13/2015	09/30/2015	07/13/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5. Develop communication for participants to be informed of I-TEAM training.	Project		Completed	07/27/2015	09/30/2015	07/27/2015	09/30/2015	09/30/2015	DY1 Q2

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Task 6. Secure I-TEAM training locations.	Project		Completed	07/24/2015	09/30/2015	07/24/2015	09/30/2015	09/30/2015	DY1 Q2
Task 7. Schedule I-TEAM training.	Project		Completed	07/24/2015	09/30/2015	07/24/2015	09/30/2015	09/30/2015	DY1 Q2
Task 8. Conduct I-TEAM training.	Project		Completed	08/17/2015	09/30/2015	08/17/2015	09/30/2015	09/30/2015	DY1 Q2
Task 9. INTERACT PM and Coach create schedule for HHA training and quarterly visits to each agency.	Project		Completed	08/24/2015	12/31/2015	08/24/2015	12/31/2015	12/31/2015	DY1 Q3
Task 10. INTERACT PM and Coach collaborate with each HHA to provide initial INTERACT training to direct care staff following certified I-TEAM training.	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. INTERACT Coach and PM perform quarterly visits to each HHA for data gathering and onsite training when required.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 12. Development of evidence-based medicine (EBM) guidelines for chronic condition management through research and collaboration of INTERACT toolkit and AHRQ Toolbox, as well as other EBM resources available.	Project		In Progress	10/05/2015	09/30/2016	10/05/2015	09/30/2016	09/30/2016	DY2 Q2
Task 13. Provider direct care staff educated on use of evidence-based guidelines for chronic-condition management.	Project		In Progress	10/19/2015	11/27/2015	10/19/2015	03/31/2017	03/31/2017	DY2 Q4
Task 14. Develop recording measure for staff to use when referencing EBM guidelines for chronic condition management.	Project		On Hold	10/05/2015	10/16/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 15. Educate necessary HHA staff regarding use of recording measure.	Project		On Hold	10/19/2015	11/27/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 16. INTERACT Coach and PM to create uniform reference materials for each HHA.	Project		Completed	10/05/2015	10/16/2015	10/05/2015	10/16/2015	12/31/2015	DY1 Q3
Task 17. INTERACT Coach and PM to distribute reference materials to each agency.	Project		In Progress	10/19/2015	11/27/2015	10/19/2015	03/31/2017	03/31/2017	DY2 Q4
Task 18. INTERACT Coach records EBM usage data at each quarterly visit.	Project		In Progress	12/01/2015	03/31/2017	12/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Project	N/A	In Progress	07/31/2015	03/31/2017	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.	Project		In Progress	07/31/2015	03/31/2017	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	Provider	Safety Net Hospital	In Progress	07/31/2015	03/31/2017	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Collaborate with HHAs to analyze INTERACT Care Pathway materials and develop reference materials for each facility	Project		In Progress	07/31/2015	12/31/2015	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Collaborate with Project 2bvii to develop recording measure for HHA staff to use when referencing INTERACT care pathways and tools.	Project		On Hold	08/24/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 3. Collaborate with Project 2bvii to create care pathway sharing system for use while providing direct patient care	Project		In Progress	08/24/2015	12/31/2015	08/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. INTERACT Coach and PM to distribute home health care specific care pathway and chronic condition monitoring reference materials and sharing system to each SNF	Project		In Progress	08/10/2015	09/30/2016	08/10/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. INTERACT Coach and PM to educate provider direct care staff on care pathway and chronic condition monitoring material	Project		In Progress	08/10/2015	09/30/2016	08/10/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6. INTERACT Coach records care pathway usage data at each quarterly visit.	Project		In Progress	11/02/2015	03/31/2017	11/02/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Agency participation in home health specific I-TEAM training.	Project		Completed	08/17/2015	12/31/2015	08/17/2015	12/31/2015	12/31/2015	DY1 Q3
Task 8. Agency identification of nurse champion.	Project		In Progress	08/11/2015	03/17/2017	08/11/2015	03/17/2017	03/31/2017	DY2 Q4
Task 9. Collaboration with each agency nurse champion and other necessary staff to strategize effective course of action to monitor	Project		In Progress	07/31/2015	12/31/2015	07/31/2015	03/31/2017	03/31/2017	DY2 Q4

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critically ill patients.									
Task 10. Development of implementation plan created for hospital avoidance and chronic condition monitoring.	Project		In Progress	08/24/2015	12/31/2015	08/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Educational materials created for direct care staff in-service on hospital avoidance and chronic condition monitoring plan.	Project		In Progress	08/24/2015	12/31/2015	08/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 12. Education provided to facility direct care staff regarding hospital avoidance and chronic condition monitoring plan and process.	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 13. Quarterly evaluations of agency implementation of hospital avoidance and chronic condition monitoring plan.	Project		In Progress	11/02/2015	09/30/2016	11/02/2015	09/30/2016	09/30/2016	DY2 Q2
Task 14. Quarterly report written documenting progress and impediments to program.	Project		In Progress	11/02/2015	03/31/2017	11/02/2015	03/31/2017	03/31/2017	DY2 Q4
Task 15. As needed consultations with PM at each agency regarding areas of weakness in program implementation.	Project		In Progress	12/02/2015	03/31/2017	12/02/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.	Project	N/A	In Progress	07/31/2015	11/27/2015	07/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	Provider	Home Care Facilities	In Progress	07/31/2015	11/27/2015	07/31/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Agency direct care staff care pathway and INTERACT principle In-Service is created, customized to home health care practice.	Project		Completed	07/31/2015	11/27/2015	07/31/2015	11/27/2015	12/31/2015	DY1 Q3
Task 2. INTERACT PM to develop training material regarding INTERACT toolkit and care pathways to be included in each home health agency's orientation materials for new employees.	Project		Completed	08/24/2015	11/27/2015	08/24/2015	11/27/2015	12/31/2015	DY1 Q3
Task 3. INTERACT Coach and PM to provide education to direct care staff of each agency regarding Care pathways and use in everyday practice.	Project		In Progress	08/10/2015	11/27/2015	08/10/2015	09/30/2016	09/30/2016	DY2 Q2
Task	Project		In Progress	08/10/2015	11/27/2015	08/10/2015	09/30/2016	09/30/2016	DY2 Q2

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4. INTERACT Coach and PM to provide education to direct care staff of each agency regarding Toolkit and use in everyday practice.									
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Project	N/A	In Progress	07/22/2015	03/31/2017	07/22/2015	03/31/2017	03/31/2017	DY2 Q4
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).	Project		In Progress	07/22/2015	03/31/2017	07/22/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Collaborate with Project 2bvii in forming Palliative Care Committee to identify gaps in Advance Care Planning Process within the home health setting and formulate policy for Advance Care Planning Procedure for home health care.	Project		Completed	07/22/2015	11/20/2015	07/22/2015	11/20/2015	12/31/2015	DY1 Q3
Task 2. Collaborate with Project 2bvii and other palliative care resources within community (e.g., The Conversation Project, Hospice Buffalo) to identify areas of overlap and/or barriers to progress.	Project		Completed	07/28/2015	11/23/2015	07/28/2015	11/23/2015	12/31/2015	DY1 Q3
Task 3. Advance care planning toolkit developed by PM using INTERACT tools and other palliative/geriatric care resources as reference (The Conversation Project, The Coalition for Compassionate Care, Closure.org, Caring Connections of the National Hospice Org).	Project		In Progress	07/23/2015	01/31/2016	07/23/2015	01/31/2016	03/31/2016	DY1 Q4
Task 4. Advance care planning toolkit distributed to HHAs.	Project		Not Started	02/01/2016	04/30/2016	02/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task 5. Social Work and other applicable direct care staff educated on Advance care planning toolkit by either PM or INTERACT coach.	Project		Not Started	02/01/2016	04/30/2016	02/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task 6. Develop recording measure for HHA staff to use when referencing Advanced Care Planning Tools.	Project		On Hold	07/28/2015	01/31/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 7. Educate necessary HHA staff regarding use of Advance Care Planning recording measure.	Project		Not Started	02/01/2016	04/30/2016	02/01/2016	04/30/2016	06/30/2016	DY2 Q1
Task 8. INTERACT coach and PM to record Advance Care Planning	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4

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metrics quarterly.									
Task 9. Measure effectiveness of Advance Care Planning tool and adjust as needed based on results.	Project		Not Started	03/31/2016	03/31/2017	03/31/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Create coaching program to facilitate and support implementation.	Project	N/A	In Progress	07/27/2015	03/31/2017	07/27/2015	03/31/2017	03/31/2017	DY2 Q4
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	Provider	Home Care Facilities	In Progress	07/27/2015	03/31/2017	07/27/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Collaborate with Project 2bvii to leverage INTERACT Coach resource for home health consultation initially.	Project		In Progress	07/27/2015	11/30/2015	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Hire INTERACT Coach specific to home health practice.	Project		On Hold	11/02/2015	11/30/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 3. INTERACT PM creates schedule for agency training and quarterly visits to each facility.	Project		Completed	08/17/2015	12/31/2015	08/17/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. INTERACT Coach and PM collaborate with each agency to provide initial INTERACT training to direct care staff.	Project		In Progress	08/10/2015	12/31/2015	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. INTERACT Coach and PM perform quarterly visits to each agency for data gathering and onsite training when required.	Project		In Progress	11/02/2015	03/31/2017	11/02/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Project	N/A	Not Started	01/04/2016	03/31/2017	01/04/2016	03/31/2017	03/31/2017	DY2 Q4
Task Patients and families educated and involved in planning of care using INTERACT-like principles.	Project		Not Started	01/04/2016	03/31/2017	01/04/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Collaborate with community providers regarding current state processes and engagement of family and resident in planning of care specific to the home health care setting. Review resources and education materials available.	Project		Not Started	01/04/2016	01/15/2016	01/04/2016	01/15/2016	03/31/2016	DY1 Q4
Task 2. Collaborate with "Voice of the Consumer" Sub-Committee to ensure cultural competence within educational materials and program.	Project		Not Started	01/04/2016	03/31/2016	01/04/2016	03/31/2016	03/31/2016	DY1 Q4

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Task 3. Collaborate with Project 2bvii to create informational resources for resident and family regarding advance care planning, chronic condition symptoms and expected course, and hospital avoidance.	Project		Not Started	01/18/2016	03/31/2016	01/18/2016	03/31/2016	03/31/2016	DY1 Q4
Task 4. Educate Social Work and other applicable direct care staff on resident/family education and informational resource hand off to resident/family.	Project		Not Started	01/25/2016	04/29/2016	01/25/2016	04/29/2016	06/30/2016	DY2 Q1
Task 5. Collaborate with Project 2bvii to create documentation tool for staff to record when family education using provided tools has been completed.	Project		Not Started	01/18/2016	03/31/2016	01/18/2016	03/31/2016	03/31/2016	DY1 Q4
Task 6. Educate staff in use of documentation tool for data recording.	Project		Not Started	01/25/2016	04/29/2016	01/25/2016	04/29/2016	06/30/2016	DY2 Q1
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	Project	N/A	In Progress	07/06/2015	09/30/2016	07/06/2015	09/30/2016	09/30/2016	DY2 Q2
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.	Project		In Progress	07/06/2015	09/30/2016	07/06/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Collaborate with community providers to analyze current integration of multidisciplinary team within the home health setting.	Project		Completed	07/06/2015	12/31/2015	07/06/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Identify needs and barriers to coordinating primary care, behavioral health, pharmacy, and other specialty services into the home health care model.	Project		Completed	07/06/2015	12/31/2015	07/06/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Develop implementation plan and methodology for care coordination across multidisciplinary team throughout the home health care setting.	Project		In Progress	11/02/2015	03/31/2016	11/02/2015	03/31/2016	03/31/2016	DY1 Q4
Task 4. Collaborate with Project 2biii to facilitate primary care physician engagement in the home health setting.	Project		In Progress	07/06/2015	09/30/2016	07/06/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Implement care coordination plan throughout providers in the	Project		Not Started	02/01/2016	09/30/2016	02/01/2016	09/30/2016	09/30/2016	DY2 Q2

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community.									
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	Project	N/A	In Progress	07/23/2015	09/30/2016	07/23/2015	09/30/2016	09/30/2016	DY2 Q2
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.	Project		In Progress	07/23/2015	09/30/2016	07/23/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Collaborate with community providers to identify current utilization and anticipated future projections for telehealth capabilities in home health practice.	Project		In Progress	07/23/2015	09/30/2016	07/23/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Share information from community providers with payers.	Project		In Progress	11/17/2015	09/30/2016	11/17/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Develop a plan for implementation of telehealth/telehealth medicine program across participating providers.	Project		In Progress	12/14/2015	09/30/2016	12/14/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Execute the telehealth implementation plan.	Project		Not Started	03/01/2016	09/30/2016	03/01/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	Project	N/A	In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Collaborate with community providers to define business requirements for EHR.	Project		In Progress	10/06/2015	03/31/2016	10/06/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Share requirements with 2ai IDS project.	Project		In Progress	02/01/2016	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Collaborate with DSRIP project 2ai to understand capabilities.	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Develop a plan for implementation across participating providers.	Project		Not Started	01/01/2016	07/29/2016	01/01/2016	07/29/2016	09/30/2016	DY2 Q2
Task 5. Execute the implementation plan.	Project		Not Started	04/11/2016	09/30/2016	04/11/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #11	Project	N/A	In Progress	08/05/2015	09/30/2016	08/05/2015	09/30/2016	09/30/2016	DY2 Q2

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Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.									
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.	Project		In Progress	08/05/2015	09/30/2016	08/05/2015	09/30/2016	09/30/2016	DY2 Q2
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	08/05/2015	09/30/2016	08/05/2015	09/30/2016	09/30/2016	DY2 Q2
Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.	Project		In Progress	08/05/2015	09/30/2016	08/05/2015	09/30/2016	09/30/2016	DY2 Q2
Task Service and quality outcome measures are reported to all stakeholders.	Project		In Progress	08/05/2015	09/30/2016	08/05/2015	09/30/2016	09/30/2016	DY2 Q2
Task 1. Create communication regarding implementation of home health care quality committee for 2bviii project to administer to community providers.	Project		Completed	08/05/2015	09/30/2015	08/05/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Formulate 2bviii home health care quality committee from respondents to communication, assuring variety of individuals from differing provider systems are accounted for.	Project		Completed	08/09/2015	09/30/2015	08/09/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Schedule quarterly home health care quality committee meetings.	Project		In Progress	11/15/2015	09/30/2016	11/15/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Create presentation of quarterly metrics and statistics from aggregated data collected at quarterly HHA contact and site visits.	Project		In Progress	11/10/2015	09/30/2016	11/10/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Present findings to home health care quality committee; discuss problem areas and areas of success that could be applied to other facilities.	Project		In Progress	11/15/2015	09/30/2016	11/15/2015	09/30/2016	09/30/2016	DY2 Q2
Task 6. Create quarterly improvement plans based on quarterly program outcomes from each HHA. Home health care quality	Project		In Progress	11/15/2015	09/30/2016	11/15/2015	09/30/2016	09/30/2016	DY2 Q2

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committee will provide quarterly reports to the MCC Clinical/Quality Committee.									
Task 7. Schedule trainings with applicable HHAs/providers who require implementation of improvement plans.	Project		In Progress	11/20/2015	09/30/2016	11/20/2015	09/30/2016	09/30/2016	DY2 Q2
Task 8. Hold improvement trainings at each applicable HHA/providers with direct care staff.	Project		In Progress	11/30/2015	09/30/2016	11/30/2015	09/30/2016	09/30/2016	DY2 Q2
Task 9. Administer HHA evaluation one month post improvement training to analyze success of remediation.	Project		Not Started	01/03/2016	09/30/2016	01/03/2016	09/30/2016	09/30/2016	DY2 Q2
Task 10. Distribute improvement plans to members of home health care quality committee via email or MCC website.	Project		In Progress	11/20/2015	09/30/2016	11/20/2015	09/30/2016	09/30/2016	DY2 Q2
Task 11. Distribute results of improvement plan implementation within facilities and lessons learned via email or MCC website.	Project		Not Started	01/10/2016	09/30/2016	01/10/2016	09/30/2016	09/30/2016	DY2 Q2
Milestone #12 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	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	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Define patient tracking requirements and metrics for enterprise DSRIP solution.	Project		In Progress	10/05/2015	01/28/2016	10/05/2015	01/28/2016	03/31/2016	DY1 Q4
Task 2. Share requirements with 2ai IDS project.	Project		In Progress	02/01/2016	03/31/2016	10/02/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Collaborate with DSRIP project 2ai and 2bvii to understand capabilities.	Project		In Progress	07/01/2015	09/30/2016	07/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. Develop a plan for implementation across HHAs.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Execute the implementation plan.	Project		Not Started	08/01/2016	03/31/2017	08/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.										
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services										
Task 1. Develop RRT model with collaboration from community providers (ED staff, HHAs, health homes).										
Task 2. Coordinate Hospital Avoidance Pilot Program training date for NFMMC ED staff.										
Task 3. Secure venue for NFMMC Pilot Program training.										
Task 4. Identify NFMMC training participants.										
Task 5. Create NFMMC invitation/communication for training.										
Task 6. Develop NFMMC presentation and training materials.										
Task 7. Train NFMMC ED staff using presentation for Pilot Program.										
Task 8. Develop metric recording and program procedure documents for NFMMC pilot.										
Task 9. Train NFMMC ED staff on data collection for Pilot Program.										
Task 10. Launch NFMMC Pilot Program.										
Task 11. Hold weekly meetings to collect metrics and discuss barriers.										
Task 12. Solidify process and procedure documents for NFMMC pilot.										
Task 13. Summarize findings from NFMMC Pilot Program and/or lessons learned from pilot programs.										
Task 14. Develop RRT model based on lessons learned from pilot programs.										
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
15. Implement RRT model at remaining hospitals.										
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.										
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	0	2	6	10	15	21	21	21	21	21
Task Evidence-based guidelines for chronic-condition management implemented.										
Task 1. Develop training plan/requirements for Home Health specific I-TEAM training.										
Task 2. Collaborate with Project 2bvii to obtain a contract with INTERACT training vendor.										
Task 3. Develop Home Health specific INTERACT training material.										
Task 4. Identify training participants.										
Task 5. Develop communication for participants to be informed of I-TEAM training.										
Task 6. Secure I-TEAM training locations.										
Task 7. Schedule I-TEAM training.										
Task 8. Conduct I-TEAM training.										
Task 9. INTERACT PM and Coach create schedule for HHA training and quarterly visits to each agency.										
Task 10. INTERACT PM and Coach collaborate with each HHA to provide initial INTERACT training to direct care staff following certified I-TEAM training.										
Task 11. INTERACT Coach and PM perform quarterly visits to each HHA for data gathering and onsite training when required.										
Task 12. Development of evidence-based medicine (EBM) guidelines										

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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 chronic condition management through research and collaboration of INTERACT toolkit and AHRQ Toolbox, as well as other EBM resources available.										
Task 13. Provider direct care staff educated on use of evidence-based guidelines for chronic-condition management.										
Task 14. Develop recording measure for staff to use when referencing EBM guidelines for chronic condition management.										
Task 15. Educate necessary HHA staff regarding use of recording measure.										
Task 16. INTERACT Coach and PM to create uniform reference materials for each HHA.										
Task 17. INTERACT Coach and PM to distribute reference materials to each agency.										
Task 18. INTERACT Coach records EBM usage data at each quarterly visit.										
Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	0	1	2	5	8	11	11	11	11	11
Task 1. Collaborate with HHAs to analyze INTERACT Care Pathway materials and develop reference materials for each facility										
Task 2. Collaborate with Project 2bvii to develop recording measure for HHA staff to use when referencing INTERACT care pathways and tools.										
Task 3. Collaborate with Project 2bvii to create care pathway sharing system for use while providing direct patient care										
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
4. INTERACT Coach and PM to distribute home health care specific care pathway and chronic condition monitoring reference materials and sharing system to each SNF										
Task 5. INTERACT Coach and PM to educate provider direct care staff on care pathway and chronic condition monitoring material										
Task 6. INTERACT Coach records care pathway usage data at each quarterly visit.										
Task 7. Agency participation in home health specific I-TEAM training.										
Task 8. Agency identification of nurse champion.										
Task 9. Collaboration with each agency nurse champion and other necessary staff to strategize effective course of action to monitor critically ill patients.										
Task 10. Development of implementation plan created for hospital avoidance and chronic condition monitoring.										
Task 11. Educational materials created for direct care staff in-service on hospital avoidance and chronic condition monitoring plan.										
Task 12. Education provided to facility direct care staff regarding hospital avoidance and chronic condition monitoring plan and process.										
Task 13. Quarterly evaluations of agency implementation of hospital avoidance and chronic condition monitoring plan.										
Task 14. Quarterly report written documenting progress and impediments to program.										
Task 15. As needed consultations with PM at each agency regarding areas of weakness in program implementation.										
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.										
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	0	2	6	10	15	21	21	21	21	21
Task 1. Agency direct care staff care pathway and INTERACT										

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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
principle In-Service is created, customized to home health care practice.										
Task 2. INTERACT PM to develop training material regarding INTERACT toolkit and care pathways to be included in each home health agency's orientation materials for new employees.										
Task 3. INTERACT Coach and PM to provide education to direct care staff of each agency regarding Care pathways and use in everyday practice.										
Task 4. INTERACT Coach and PM to provide education to direct care staff of each agency regarding Toolkit and use in everyday practice.										
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										
Task 1. Collaborate with Project 2bvii in forming Palliative Care Committee to identify gaps in Advance Care Planning Process within the home health setting and formulate policy for Advance Care Planning Procedure for home health care.										
Task 2. Collaborate with Project 2bvii and other palliative care resources within community (e.g., The Conversation Project, Hospice Buffalo) to identify areas of overlap and/or barriers to progress.										
Task 3. Advance care planning toolkit developed by PM using INTERACT tools and other palliative/geriatric care resources as reference (The Conversation Project, The Coalition for Compassionate Care, Closure.org, Caring Connections of the National Hospice Org).										
Task 4. Advance care planning toolkit distributed to HHAs.										
Task 5. Social Work and other applicable direct care staff educated on Advance care planning toolkit by either PM or INTERACT coach.										
Task 6. Develop recording measure for HHA staff to use when referencing Advanced Care Planning Tools.										

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Task 7. Educate necessary HHA staff regarding use of Advance Care Planning recording measure.										
Task 8. INTERACT coach and PM to record Advance Care Planning metrics quarterly.										
Task 9. Measure effectiveness of Advance Care Planning tool and adjust as needed based on results.										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	0	2	6	10	15	21	21	21	21	21
Task 1. Collaborate with Project 2bvii to leverage INTERACT Coach resource for home health consultation initially.										
Task 2. Hire INTERACT Coach specific to home health practice.										
Task 3. INTERACT PM creates schedule for agency training and quarterly visits to each facility.										
Task 4. INTERACT Coach and PM collaborate with each agency to provide initial INTERACT training to direct care staff.										
Task 5. INTERACT Coach and PM perform quarterly visits to each agency for data gathering and onsite training when required.										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT-like principles.										
Task 1. Collaborate with community providers regarding current state processes and engagement of family and resident in planning of care specific to the home health care setting. Review resources and education materials available.										
Task 2. Collaborate with "Voice of the Consumer" Sub-Committee to ensure cultural competence within educational materials and program.										

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Task 3. Collaborate with Project 2bvii to create informational resources for resident and family regarding advance care planning, chronic condition symptoms and expected course, and hospital avoidance.										
Task 4. Educate Social Work and other applicable direct care staff on resident/family education and informational resource hand off to resident/family.										
Task 5. Collaborate with Project 2bvii to create documentation tool for staff to record when family education using provided tools has been completed.										
Task 6. Educate staff in use of documentation tool for data recording.										
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.										
Task All relevant services (physical, behavioral, pharmacological) integrated into care and medication management model.										
Task 1. Collaborate with community providers to analyze current integration of multidisciplinary team within the home health setting.										
Task 2. Identify needs and barriers to coordinating primary care, behavioral health, pharmacy, and other specialty services into the home health care model.										
Task 3. Develop implementation plan and methodology for care coordination across multidisciplinary team throughout the home health care setting.										
Task 4. Collaborate with Project 2biii to facilitate primary care physician engagement in the home health setting.										
Task 5. Implement care coordination plan throughout providers in the community.										
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.										
Task Telehealth/telemedicine program established to provide care										

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transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.										
Task 1. Collaborate with community providers to identify current utilization and anticipated future projections for telehealth capabilities in home health practice.										
Task 2. Share information from community providers with payers.										
Task 3. Develop a plan for implementation of telehealth/telehealth medicine program across participating providers.										
Task 5. Execute the telehealth implementation plan.										
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.										
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.										
Task 1. Collaborate with community providers to define business requirements for EHR.										
Task 2. Share requirements with 2ai IDS project.										
Task 3. Collaborate with DSRIP project 2ai to understand capabilities.										
Task 4. Develop a plan for implementation across participating providers.										
Task 5. Execute the implementation plan.										
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
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.										

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Task PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 1. Create communication regarding implementation of home health care quality committee for 2bviii project to administer to community providers.										
Task 2. Formulate 2bviii home health care quality committee from respondents to communication, assuring variety of individuals from differing provider systems are accounted for.										
Task 3. Schedule quarterly home health care quality committee meetings.										
Task 4. Create presentation of quarterly metrics and statistics from aggregated data collected at quarterly HHA contact and site visits.										
Task 5. Present findings to home health care quality committee; discuss problem areas and areas of success that could be applied to other facilities.										
Task 6. Create quarterly improvement plans based on quarterly program outcomes from each HHA. Home health care quality committee will provide quarterly reports to the MCC Clinical/Quality Committee.										
Task 7. Schedule trainings with applicable HHAs/providers who require implementation of improvement plans.										
Task 8. Hold improvement trainings at each applicable HHA/providers with direct care staff.										
Task 9. Administer HHA evaluation one month post improvement training to analyze success of remediation.										
Task 10. Distribute improvement plans to members of home health care quality committee via email or MCC website.										
Task 11. Distribute results of improvement plan implementation within facilities and lessons learned via email or MCC website.										

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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 #12 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. Define patient tracking requirements and metrics for enterprise DSRIP solution.										
Task 2. Share requirements with 2ai IDS project.										
Task 3. Collaborate with DSRIP project 2ai and 2bvii to understand capabilities.										
Task 4. Develop a plan for implementation across HHAs.										
Task 5. Execute the implementation plan.										

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 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.										
Task Rapid Response Teams are facilitating hospital-home care collaboration, with procedures and protocols for: - discharge planning - discharge facilitation - confirmation of home care services										
Task 1. Develop RRT model with collaboration from community providers (ED staff, HHAs, health homes).										
Task 2. Coordinate Hospital Avoidance Pilot Program training date for NFMMC ED staff.										
Task 3. Secure venue for NFMMC Pilot Program training.										
Task 4. Identify NFMMC training participants.										
Task 5. Create NFMMC invitation/communication for 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 6. Develop NFMMC presentation and training materials.										
Task 7. Train NFMMC ED staff using presentation for Pilot Program.										
Task 8. Develop metric recording and program procedure documents for NFMMC pilot.										
Task 9. Train NFMMC ED staff on data collection for Pilot Program.										
Task 10. Launch NFMMC Pilot Program.										
Task 11. Hold weekly meetings to collect metrics and discuss barriers.										
Task 12. Solidify process and procedure documents for NFMMC pilot.										
Task 13. Summarize findings from NFMMC Pilot Program and/or lessons learned from pilot programs.										
Task 14. Develop RRT model based on lessons learned from pilot programs.										
Task 15. Implement RRT model at remaining hospitals.										
Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.										
Task Staff trained on care model, specific to: - patient risks for readmission - evidence-based preventive medicine - chronic disease management	21	21	21	21	21	21	21	21	21	21
Task Evidence-based guidelines for chronic-condition management implemented.										
Task 1. Develop training plan/requirements for Home Health specific I-TEAM training.										
Task 2. Collaborate with Project 2bvii to obtain a contract with INTERACT training vendor.										
Task 3. Develop Home Health specific INTERACT training material.										
Task										

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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
4. Identify training participants.										
Task 5. Develop communication for participants to be informed of I-TEAM training.										
Task 6. Secure I-TEAM training locations.										
Task 7. Schedule I-TEAM training.										
Task 8. Conduct I-TEAM training.										
Task 9. INTERACT PM and Coach create schedule for HHA training and quarterly visits to each agency.										
Task 10. INTERACT PM and Coach collaborate with each HHA to provide initial INTERACT training to direct care staff following certified I-TEAM training.										
Task 11. INTERACT Coach and PM perform quarterly visits to each HHA for data gathering and onsite training when required.										
Task 12. Development of evidence-based medicine (EBM) guidelines for chronic condition management through research and collaboration of INTERACT toolkit and AHRQ Toolbox, as well as other EBM resources available.										
Task 13. Provider direct care staff educated on use of evidence-based guidelines for chronic-condition management.										
Task 14. Develop recording measure for staff to use when referencing EBM guidelines for chronic condition management.										
Task 15. Educate necessary HHA staff regarding use of recording measure.										
Task 16. INTERACT Coach and PM to create uniform reference materials for each HHA.										
Task 17. INTERACT Coach and PM to distribute reference materials to each agency.										
Task 18. INTERACT Coach records EBM usage data at each quarterly visit.										

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Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.										
Task Care pathways and clinical tool(s) created to monitor chronically-ill patients.										
Task PPS has developed and implemented interventions aimed at avoiding eventual hospital transfer and has trained staff on use of interventions in alignment with the PPS strategic plan to monitor critically ill patients and avoid hospital readmission.	11	11	11	11	11	11	11	11	11	11
Task 1. Collaborate with HHAs to analyze INTERACT Care Pathway materials and develop reference materials for each facility										
Task 2. Collaborate with Project 2bvii to develop recording measure for HHA staff to use when referencing INTERACT care pathways and tools.										
Task 3. Collaborate with Project 2bvii to create care pathway sharing system for use while providing direct patient care										
Task 4. INTERACT Coach and PM to distribute home health care specific care pathway and chronic condition monitoring reference materials and sharing system to each SNF										
Task 5. INTERACT Coach and PM to educate provider direct care staff on care pathway and chronic condition monitoring material										
Task 6. INTERACT Coach records care pathway usage data at each quarterly visit.										
Task 7. Agency participation in home health specific I-TEAM training.										
Task 8. Agency identification of nurse champion.										
Task 9. Collaboration with each agency nurse champion and other necessary staff to strategize effective course of action to monitor critically ill patients.										
Task 10. Development of implementation plan created for hospital avoidance and chronic condition monitoring.										
Task										

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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
11. Educational materials created for direct care staff in-service on hospital avoidance and chronic condition monitoring plan.										
Task 12. Education provided to facility direct care staff regarding hospital avoidance and chronic condition monitoring plan and process.										
Task 13. Quarterly evaluations of agency implementation of hospital avoidance and chronic condition monitoring plan.										
Task 14. Quarterly report written documenting progress and impediments to program.										
Task 15. As needed consultations with PM at each agency regarding areas of weakness in program implementation.										
Milestone #4 Educate all staff on care pathways and INTERACT-like principles.										
Task Training program for all home care staff established, which encompasses care pathways and INTERACT-like principles.	21	21	21	21	21	21	21	21	21	21
Task 1. Agency direct care staff care pathway and INTERACT principle In-Service is created, customized to home health care practice.										
Task 2. INTERACT PM to develop training material regarding INTERACT toolkit and care pathways to be included in each home health agency's orientation materials for new employees.										
Task 3. INTERACT Coach and PM to provide education to direct care staff of each agency regarding Care pathways and use in everyday practice.										
Task 4. INTERACT Coach and PM to provide education to direct care staff of each agency regarding Toolkit and use in everyday practice.										
Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.										
Task Advance Care Planning tools incorporated into program (as evidenced by policies and procedures).										

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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. Collaborate with Project 2bvii in forming Palliative Care Committee to identify gaps in Advance Care Planning Process within the home health setting and formulate policy for Advance Care Planning Procedure for home health care.										
Task 2. Collaborate with Project 2bvii and other palliative care resources within community (e.g., The Conversation Project, Hospice Buffalo) to identify areas of overlap and/or barriers to progress.										
Task 3. Advance care planning toolkit developed by PM using INTERACT tools and other palliative/geriatric care resources as reference (The Conversation Project, The Coalition for Compassionate Care, Closure.org, Caring Connections of the National Hospice Org).										
Task 4. Advance care planning toolkit distributed to HHAs.										
Task 5. Social Work and other applicable direct care staff educated on Advance care planning toolkit by either PM or INTERACT coach.										
Task 6. Develop recording measure for HHA staff to use when referencing Advanced Care Planning Tools.										
Task 7. Educate necessary HHA staff regarding use of Advance Care Planning recording measure.										
Task 8. INTERACT coach and PM to record Advance Care Planning metrics quarterly.										
Task 9. Measure effectiveness of Advance Care Planning tool and adjust as needed based on results.										
Milestone #6 Create coaching program to facilitate and support implementation.										
Task INTERACT-like coaching program has been established for all home care and Rapid Response Team staff.	21	21	21	21	21	21	21	21	21	21
Task 1. Collaborate with Project 2bvii to leverage INTERACT Coach resource for home health consultation initially.										
Task 2. Hire INTERACT Coach specific to home health practice.										

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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. INTERACT PM creates schedule for agency training and quarterly visits to each facility.										
Task 4. INTERACT Coach and PM collaborate with each agency to provide initial INTERACT training to direct care staff.										
Task 5. INTERACT Coach and PM perform quarterly visits to each agency for data gathering and onsite training when required.										
Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.										
Task Patients and families educated and involved in planning of care using INTERACT-like principles.										
Task 1. Collaborate with community providers regarding current state processes and engagement of family and resident in planning of care specific to the home health care setting. Review resources and education materials available.										
Task 2. Collaborate with "Voice of the Consumer" Sub-Committee to ensure cultural competence within educational materials and program.										
Task 3. Collaborate with Project 2bvii to create informational resources for resident and family regarding advance care planning, chronic condition symptoms and expected course, and hospital avoidance.										
Task 4. Educate Social Work and other applicable direct care staff on resident/family education and informational resource hand off to resident/family.										
Task 5. Collaborate with Project 2bvii to create documentation tool for staff to record when family education using provided tools has been completed.										
Task 6. Educate staff in use of documentation tool for data recording.										
Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.										
Task All relevant services (physical, behavioral, pharmacological)										

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Millennium Collaborative Care (PPS ID:48)

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
integrated into care and medication management model.										
Task 1. Collaborate with community providers to analyze current integration of multidisciplinary team within the home health setting.										
Task 2. Identify needs and barriers to coordinating primary care, behavioral health, pharmacy, and other specialty services into the home health care model.										
Task 3. Develop implementation plan and methodology for care coordination across multidisciplinary team throughout the home health care setting.										
Task 4. Collaborate with Project 2biii to facilitate primary care physician engagement in the home health setting.										
Task 5. Implement care coordination plan throughout providers in the community.										
Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.										
Task Telehealth/telemedicine program established to provide care transition services, prevent avoidable hospital use, and increase specialty expertise of PCPs and staff.										
Task 1. Collaborate with community providers to identify current utilization and anticipated future projections for telehealth capabilities in home health practice.										
Task 2. Share information from community providers with payers.										
Task 3. Develop a plan for implementation of telehealth/telehealth medicine program across participating providers.										
Task 5. Execute the telehealth implementation plan.										
Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.										
Task Clinical Interoperability System in place for all participating providers. Usage documented by the identified care coordinators.										

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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. Collaborate with community providers to define business requirements for EHR.										
Task 2. Share requirements with 2ai IDS project.										
Task 3. Collaborate with DSRIP project 2ai to understand capabilities.										
Task 4. Develop a plan for implementation across participating providers.										
Task 5. Execute the implementation plan.										
Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
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 in Attachment J.										
Task Service and quality outcome measures are reported to all stakeholders.										
Task 1. Create communication regarding implementation of home health care quality committee for 2bviii project to administer to community providers.										
Task 2. Formulate 2bviii home health care quality committee from respondents to communication, assuring variety of individuals from differing provider systems are accounted for.										
Task 3. Schedule quarterly home health care quality committee meetings.										
Task 4. Create presentation of quarterly metrics and statistics from aggregated data collected at quarterly HHA contact and site										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
visits.										
Task 5. Present findings to home health care quality committee; discuss problem areas and areas of success that could be applied to other facilities.										
Task 6. Create quarterly improvement plans based on quarterly program outcomes from each HHA. Home health care quality committee will provide quarterly reports to the MCC Clinical/Quality Committee.										
Task 7. Schedule trainings with applicable HHAs/providers who require implementation of improvement plans.										
Task 8. Hold improvement trainings at each applicable HHA/providers with direct care staff.										
Task 9. Administer HHA evaluation one month post improvement training to analyze success of remediation.										
Task 10. Distribute improvement plans to members of home health care quality committee via email or MCC website.										
Task 11. Distribute results of improvement plan implementation within facilities and lessons learned via email or MCC website.										
Milestone #12 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. Define patient tracking requirements and metrics for enterprise DSRIP solution.										
Task 2. Share requirements with 2ai IDS project.										
Task 3. Collaborate with DSRIP project 2ai and 2bvii to understand capabilities.										
Task 4. Develop a plan for implementation across HHAs.										
Task 5. Execute the implementation plan.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Tasks #1–13 have been completed, and remaining tasks are expected to begin on schedule.
Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	We have completed tasks #1–9 in this milestone and the remaining tasks are progressing as expected. Tasks 14 and 15 were determined to be unnecessary.
Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	All tasks have been initiated on schedule and are progressing as expected. Task #2 was determined to be unnecessary.
Educate all staff on care pathways and INTERACT-like principles.	Tasks #1-2 have been completed, and other tasks began as scheduled. End dates were adjusted to correct a previous error.
Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	All scheduled tasks have been initiated on schedule and are progressing as expected. Task #6 was determined to be unnecessary.
Create coaching program to facilitate and support implementation.	Most tasks are progressing as expected. Scheduling initial in-person visits with home care agencies has taken longer than initially anticipated due to home care staff schedules. Task #2 was determined to be unnecessary.
Educate patient and family/caretakers, to facilitate participation in planning of care.	
Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	All scheduled tasks have been initiated on schedule and are progressing as expected.
Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	
Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	All scheduled tasks are progressing as expected.
Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	All scheduled tasks have been initiated on schedule and are progressing as expected.
Use EHRs and other technical platforms to track all patients engaged in the project.	All scheduled tasks have been initiated on schedule and are progressing as expected.

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 2.b.viii.5 - 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.

MCC is unable to locate enough Community Based Organizations (CBOs) with the capacity to provide culturally competent education, outreach, and navigation to meet the speed and scale targets. Through an RFP process, MCC has identified CBOs to perform this work. The CBO Task Force has also been activated to build connections to CBOs.

Patient activation efforts do not account for the cultural and linguistic diversity and health literacy needs of the region. Beneficiary may not be willing to provide baseline information or participate in reassessments. Create a cross-cultural, multilingual training team to provide IT support and training where CBOs and their teams are located. Provide cultural competency and health literacy training to CBOs, utilize "train the trainer" techniques, and include key staff to assure cultural and linguistic diversity is addressed. Work with the Cultural Competency/Health Literacy workstream to design communication materials that are effective for their intended audiences. Equip CBOs and their community health workers (CHWs) with culturally sensitive engagement tools, including understandable health education materials to encourage an individual to participate in the PAM survey. CHWs must create a trusting, working relationship to facilitate and encourage reassessment at prescribed intervals over the course of the project.

There is considerable county overlap with two adjacent PPSs in WNY. It will be important to provide a relatively uniform/transparent experience for patients regardless of where they seek care. MCC will work with area PPSs to coordinate logistics including registry information, standardized referral protocols, uniform tracking and reporting systems, universal alert messaging via the RHIO, and common messaging to educate patients about patient activation.

Medicaid managed care organizations (MMCOs) may be reluctant to disclose/distribute data about non-utilizing beneficiaries. Develop memoranda of understanding with MMCOs addressing privacy, security, and consent concerns related to acquiring non-utilizing (NU) member data.

The lack of up-to-date patient information coupled with the transient nature of the NU population makes it difficult to locate and reconnect this population to PCPs. Engagement efforts with community partners in navigation while assisting to create useful tools that provide community-oriented lists of PCPs with capacity to take new patients. Additionally assistive efforts to cross-reference MMCO data against a variety of databases to obtain current contact information.

NUs remain dissatisfied with their current PCP or MMCO, which accounts for their disengagement. Provide training how beneficiaries can appropriately change their provider.

Complaints and grievances about the project and other service components of the PPS, when not addressed and resolved, lead to consumer

dissatisfaction. Create a process to handle complaints quickly and effectively. Convene the "Voice of the Consumer" Sub-Committee as a patient advocacy team and to ensure representation from a broad range of culturally diverse patients.

Lack of common EHR and IT system to manage and track patients and provide assessment and feedback to PCPs and MMCOs. Develop a common EHR and IT system for sharing of data, communication, and feedback that allow evaluation of the success. Organize user groups to discuss issues and share lessons learned. Periodically assess tools to determine consistency and effectiveness; provide follow-up training as needed.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	81,000

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
4,816	10,016	82.10%	2,184	12.37%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (12,200)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ethelen	Baseline or Performance Documentation	48_PMDL3615_1_3_20160202181626_2di_PE_registry_DY1Q3.xlsx	Patient engagement registry showing 5,200 patients engaged for Q3	02/02/2016 06:17 PM

Narrative Text :

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

patients previously reported in DY1 Q2: 4,816. new patients engaged in DY1 Q3: 5,200. cumulative total: 10,016

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 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	05/28/2015	03/31/2017	05/28/2015	03/31/2017	03/31/2017	DY2 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	05/28/2015	03/31/2017	05/28/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Launch community awareness and communication regarding DSRIP. Identify key areas in the north, south, and central areas to hold community forums to bring awareness to DSRIP. Hold community forums throughout the eight counties to provide community education regarding DSRIP.	Project		Completed	05/28/2015	08/31/2015	05/28/2015	08/31/2015	09/30/2015	DY1 Q2
Task 2. Work with CBO Task Force to provide outreach and education regarding DSRIP.	Project		Completed	05/28/2015	08/31/2015	05/28/2015	08/31/2015	09/30/2015	DY1 Q2
Task 3. Create CBO Implementation Plan.	Project		Completed	07/13/2015	08/31/2015	07/13/2015	08/31/2015	09/30/2015	DY1 Q2
Task 4. Select CBOs to serve as PAM vendor(s) via RFQ/RFP process.	Project		Completed	05/28/2015	08/31/2015	05/28/2015	08/31/2015	09/30/2015	DY1 Q2
Task 5. Develop materials to support PAM vendors including patient-level reporting tool; train vendors on use of materials/tools.	Project		Completed	07/20/2015	08/31/2015	07/20/2015	08/31/2015	09/30/2015	DY1 Q2
Task 6. Host first quarterly meeting with "Voice of the Consumer" Sub-Committee and MCC/PPS team.	Project		Completed	05/28/2015	06/30/2015	05/28/2015	06/30/2015	06/30/2015	DY1 Q1
Task 7. Develop and execute contracts with CBOs.	Project		Completed	07/15/2015	10/30/2015	07/15/2015	10/30/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 8. Develop reporting requirements and metrics for each CBO. Continue to monitor metrics throughout project.	Project		Completed	08/14/2015	09/30/2015	08/14/2015	09/30/2015	09/30/2015	DY1 Q2
Task 9. Identify a PAM Administrator within each CBO.	Project		Completed	07/15/2015	09/30/2015	07/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task 10. For target population Non-Utilizers: Work with DOH to obtain a listing of PAM-eligible non-utilizers; distribute report to CBOs.	Project		Not Started	04/01/2015	03/31/2020	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 11. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of approach, and allow for continuous improvement over time.	Project		In Progress	09/04/2015	03/31/2017	09/04/2015	03/31/2017	03/31/2017	DY2 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	05/05/2015	03/31/2017	05/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patient Activation Measure(R) (PAM(R)) training team established.	Project		In Progress	05/05/2015	03/31/2017	05/05/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Establish PPS-wide training team (ensure participation from candidates who represent all of MCC's geographic areas); identify training team goals.	Project		Completed	05/05/2015	05/28/2015	05/05/2015	05/28/2015	06/30/2015	DY1 Q1
Task 2. Contact Insignia about conducting PAM training. Resolve the number of Flourish (PAM) licenses across the state.	Project		Completed	05/05/2015	05/28/2015	05/05/2015	05/28/2015	06/30/2015	DY1 Q1
Task 3. Develop plan for training (e.g., train the trainer). Plan to offer training in a variety of formats (onsite, web-based, teleconference).	Project		Completed	05/28/2015	05/28/2015	05/28/2015	05/28/2015	06/30/2015	DY1 Q1
Task 4. Work with selected CBOs/vendors to identify training participants.	Project		Completed	05/28/2015	05/28/2015	05/28/2015	05/28/2015	06/30/2015	DY1 Q1
Task 5. Insignia contract signed.	Project		Completed	05/05/2015	06/23/2015	05/05/2015	06/23/2015	06/30/2015	DY1 Q1
Task 6. Develop training materials for community health workers who will be administering PAM.	Project		Completed	05/05/2015	09/30/2015	05/05/2015	09/30/2015	09/30/2015	DY1 Q2
Task	Project		Completed	05/28/2015	09/30/2015	05/28/2015	09/30/2015	09/30/2015	DY1 Q2

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
7. Identify training locations covering the 8 counties of WNY; schedule training sessions.									
Task 8. Hold first PAM training session for community health workers.	Project		Completed	06/24/2015	06/25/2015	06/24/2015	06/25/2015	06/30/2015	DY1 Q1
Task 9. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of training, and allow for continuous improvement over time.	Project		In Progress	06/24/2015	03/31/2017	06/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 10. Continue to offer training as needed.	Project		In Progress	06/24/2015	03/31/2017	06/24/2015	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop hot spot maps; provide maps with zip codes to CBOs that requested the information.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. For target population Uninsured: Develop plan to outreach to and communicate with the uninsured population.	Project		Completed	08/03/2015	12/31/2015	08/03/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Promote / focus outreach efforts on target areas including local festivals, fairs, church groups, and the part-time workforce.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Continue conducting outreach.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Develop market share model to understand location and distribution of UI and NU populations.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 6. Develop CBO workforce model to ensure adequate coverage is available to engage the target populations. Engage additional CBOs as necessary (See also Milestone#1).	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Collaborate with ED Care Triage project team to include PAM® as appropriate in "hot spot" EDs.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
8. Renew market share model annually and assess progress vs. milestone goals and adjust plan accordingly.									
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Project	N/A	Completed	04/01/2015	07/01/2015	04/01/2015	07/01/2015	09/30/2015	DY1 Q2
Task Community engagement forums and other information-gathering mechanisms established and performed.	Project		Completed	04/01/2015	07/01/2015	04/01/2015	07/01/2015	09/30/2015	DY1 Q2
Task 1. Review community needs assessment, and collaborate with CBOs, P2 Collaborative, and county community action plans to update the targeted population's healthcare needs in MCC network.	Project		Completed	04/01/2015	07/01/2015	04/01/2015	07/01/2015	09/30/2015	DY1 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.	Project	N/A	In Progress	05/28/2015	03/31/2017	05/28/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".	Project		In Progress	05/28/2015	03/31/2017	05/28/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop plan for training (e.g., train the trainer). Plan to offer training in a variety of formats (onsite, web-based, teleconference).	Project		Completed	05/28/2015	06/30/2015	05/28/2015	06/30/2015	06/30/2015	DY1 Q1
Task 2. Develop a list of targeted providers with the "hot spots" areas.	Project		Completed	07/01/2015	08/31/2015	07/01/2015	08/31/2015	09/30/2015	DY1 Q2
Task 3. Develop communication to providers.	Project		In Progress	07/17/2015	10/30/2015	07/17/2015	01/29/2016	03/31/2016	DY1 Q4
Task 4. Ensure BAA is in place with all providers.	Project		In Progress	09/01/2015	10/30/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5. Develop training material for PPS providers. Obtain state review/approve of any educational materials as required; ensure materials comply with state marketing guidelines and federal regulations as applicable.	Project		Completed	07/01/2015	10/30/2015	07/01/2015	10/30/2015	12/31/2015	DY1 Q3
Task 6. Identify training locations covering the 8 counties of WNY; schedule training sessions.	Project		In Progress	09/01/2015	10/30/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		Not Started	10/01/2015	12/31/2015	03/01/2016	03/31/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
7. Hold first provider training session.									
Task 8. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of training, and allow for continuous improvement over time.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Continue to offer training as needed.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 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	06/01/2015	03/31/2017	06/01/2015	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	06/01/2015	03/31/2017	06/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Work with Independent Health IT security, reporting, and MCO to develop a secure file transfer process and data formats.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Develop and execute a signed BAA addendum with Independent Health MCO.	Project		Completed	07/01/2015	10/30/2015	07/01/2015	10/30/2015	12/31/2015	DY1 Q3
Task 3. Receive data from Independent Health.	Project		Completed	11/02/2015	12/31/2015	11/02/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Match internal PPS attribution reporting (from DOH) against Independent Health data.	Project		On Hold	11/02/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 5. Finalize Independent Health report with PAM candidates identified.	Project		On Hold	11/02/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 6. Deliver Independent Health Non-Utilizers report to CBOs/vendors.	Project		In Progress	11/02/2015	12/31/2015	11/02/2015	01/31/2016	03/31/2016	DY1 Q4
Task 7. Receive ongoing Independent Health data feed to support measurement process (refreshed on a quarterly basis).	Project		Not Started	11/02/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Work with HealthNow IT security, reporting, and MCO to develop a secure file transfer process and data formats.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 9. Develop and execute a signed BAA addendum with HealthNow MCO.	Project		Completed	07/01/2015	10/30/2015	07/01/2015	10/30/2015	12/31/2015	DY1 Q3
Task 10. Receive data from HealthNow.	Project		Completed	11/02/2015	12/31/2015	11/02/2015	12/31/2015	12/31/2015	DY1 Q3
Task 11. Match internal PPS attribution reporting (from DOH) against HealthNow data.	Project		On Hold	11/02/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 12. Finalize HealthNow report with PAM candidates identified.	Project		On Hold	11/02/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task 13. Deliver HealthNow Non-Utilizers report to CBOs/vendors.	Project		In Progress	11/02/2015	12/31/2015	11/02/2015	01/31/2016	03/31/2016	DY1 Q4
Task 14. Receive ongoing HealthNow data feed to support measurement process (refreshed on a quarterly basis).	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 15. Work with Fidelis IT security, reporting, and MCO to develop a secure file transfer process and data formats.	Project		Not Started	04/01/2016	10/31/2016	04/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task 16. Develop and execute a signed BAA addendum with Fidelis MCO.	Project		Not Started	04/01/2016	07/29/2016	04/01/2016	07/29/2016	09/30/2016	DY2 Q2
Task 17. Receive data from Fidelis.	Project		Not Started	08/01/2016	10/31/2016	08/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task 18. Match internal PPS attribution reporting (from DOH) against Fidelis data.	Project		Not Started	08/01/2016	10/31/2016	08/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task	Project		Not Started	08/01/2016	10/31/2016	08/01/2016	10/31/2016	12/31/2016	DY2 Q3

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19. Finalize Fidelis report with PAM candidates identified.									
Task 20. Deliver Fidelis Non-Utilizers report to CBOs/vendors.	Project		Not Started	08/01/2016	10/31/2016	08/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task 21. Receive ongoing Fidelis data feed to support measurement process (refreshed on a quarterly basis).	Project		Not Started	11/01/2016	03/31/2017	11/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 22. Work with YourCare IT security, reporting, and MCO to develop a secure file transfer process and data formats.	Project		Not Started	04/01/2016	10/31/2016	04/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task 23. Develop and execute a signed BAA addendum with YourCare MCO.	Project		Not Started	04/01/2016	07/29/2016	04/01/2016	07/29/2016	09/30/2016	DY2 Q2
Task 24. Receive data from YourCare.	Project		Not Started	08/01/2016	10/31/2016	08/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task 25. Match internal PPS attribution reporting (from DOH) against YourCare data.	Project		Not Started	08/01/2016	10/31/2016	08/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task 26. Finalize YourCare report with PAM candidates identified.	Project		Not Started	08/01/2016	10/31/2016	08/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task 27. Deliver YourCare Non-Utilizers report to CBOs/vendors.	Project		Not Started	08/01/2016	10/31/2016	08/01/2016	10/31/2016	12/31/2016	DY2 Q3
Task 28. Receive ongoing YourCare data feed to support measurement process (refreshed on a quarterly basis).	Project		Not Started	11/01/2016	03/31/2017	11/01/2016	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Complete PAM target goal; determine baseline PAM scores.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Update baseline annually; re-PAM same beneficiaries.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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3. Continue to monitor scores.									
Milestone #8 Include beneficiaries in development team to promote preventive care.	Project	N/A	In Progress	05/01/2015	03/31/2017	05/01/2015	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	05/01/2015	03/31/2017	05/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Populate CBO Task Force (as described in Governance requirement #5) by conducting outreach at community forums across PPS region and receiving nominations for CBO representatives. Ensure representation from all eight counties of WNY.	Project		Completed	05/01/2015	09/30/2015	05/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Populate "Voice of the Consumer" Sub-Committee (as described in Governance requirement #5) by conducting outreach at community forums and receiving nominations for Medicaid beneficiaries. Create protocols for engaging PAM beneficiaries in "Voice of the Consumer" Sub-Committee.	Project		Completed	05/15/2015	09/30/2015	05/15/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. "Voice of the Consumer" Sub-Committee will review materials to be presented to beneficiaries to ensure appropriateness of message, evaluate effectiveness, and account for variations in health literacy.	Project		In Progress	05/15/2015	06/30/2016	05/15/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Attend first quarterly CBO Task Force/"Voice of the Consumer" Sub-Committee meeting. Meetings will continue quarterly.	Project		In Progress	09/15/2015	03/31/2017	09/15/2015	03/31/2017	03/31/2017	DY2 Q4
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.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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• 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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Establish protocol for data collection and reporting of screenings and bridges.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Ensure details are included in training program for CBOs.	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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3. Establish procedures for obtaining data for quarterly reporting including PAM data by activation level and scoring, clinicians trained, and CBO/CHW evidence of patient bridges established.									
Task 4. Establish procedures for obtaining quarterly refresh of MCO data feeds with visit information (include in report per requirement 10).	Project		Not Started	10/01/2015	12/31/2015	07/01/2016	07/29/2016	09/30/2016	DY2 Q2
Task 5. Finalize reporting processes and procedures; produce quarterly report.	Project		Completed	11/02/2015	12/31/2015	11/02/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Continue to refine quarterly reporting process and produce quarterly reports.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Project	N/A	Not Started	11/01/2015	03/31/2017	01/04/2016	03/31/2017	03/31/2017	DY2 Q4
Task Volume of non-emergent visits for UI, NU, and LU populations increased.	Project		Not Started	11/01/2015	03/31/2017	01/04/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Obtain quarterly visit info from MCOs based on original target population membership (or from DOH as available); calculate volume of non-emergent visits and report quarterly.	Project		Not Started	01/05/2016	03/31/2017	01/05/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Leverage efforts (Cultural Competency, milestone #1) to improve overall health literacy of targeted populations (e.g., when to use the ED, importance of primary care, overcoming mental health stigma, navigating the health system, and questions to ask your provider).	Project		Not Started	11/01/2015	03/31/2017	01/05/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Develop materials with input from patients. Distribute materials at locations appropriate to the target population (Cultural Competency, milestone #1).	Project		Not Started	11/01/2015	03/31/2017	01/05/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Use public awareness, education, and other programs to address and increase the volume of non-emergent visits in the targeted population groups.	Project		Not Started	01/04/2016	03/31/2017	01/04/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Contract or partner with CBOs to develop a group of community	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Provider	PAM(R) Providers	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Per the steps defined for requirement #1, ensure CBO contracts are completed and CBOs are engaged.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Continuously monitor CBO performance. Make adjustments to partnerships and/or contracts as needed.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Per tasks in milestones 2, 13, and 15, training for navigators is planned, organized, monitored, and controlled.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures for customer service complaints and appeals developed.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. PPS will research leading practice models to inform development of protocols.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. PPS will develop protocols for complaints and customer service to support PPS-wide complaint communication and individual complaint follow-up.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Review protocols with "Voice of the Consumer" Sub-Committee.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Determine process owner and MCC lead.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Determine platform for complaint tracking.	Project		Completed	09/01/2015	10/30/2015	09/01/2015	10/30/2015	12/31/2015	DY1 Q3
Task	Project		Completed	11/01/2015	12/31/2015	11/01/2015	12/31/2015	12/31/2015	DY1 Q3

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6. Obtain MCC Board of Managers and PMO approvals.									
Task 7. Implement complaint tracking and follow-up processes.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 8. Initiate PDSA cycles to assess customer satisfaction and allow for continuous improvement over time.	Project		Not Started	01/01/2016	03/31/2017	01/01/2016	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	08/03/2015	03/31/2017	08/03/2015	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	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop plan for training (e.g., train the trainer). Plan to offer training in a variety of formats (onsite, web-based, teleconference).	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Identify who is being trained. Create attendee roster.	Project		Completed	08/03/2015	10/20/2015	08/03/2015	10/20/2015	12/31/2015	DY1 Q3
Task 3. Develop training material for community navigators.	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Identify training locations covering the 8 counties of WNY; schedule training sessions.	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task 5. Hold first community navigator training sessions. Capture attendee information for subsequent reporting	Project		Completed	09/01/2015	09/30/2015	09/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 6. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of training, and allow for continuous improvement over time.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 7. Continue to offer training as needed.	Project		In Progress	09/30/2015	03/31/2017	09/30/2015	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	07/01/2015	12/30/2016	07/01/2015	12/30/2016	12/31/2016	DY2 Q3
Task	Provider	PAM(R) Providers	In Progress	07/01/2015	12/30/2016	07/01/2015	12/30/2016	12/31/2016	DY2 Q3

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Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.									
Task 1. Engage CBOs in hot spots who will participate in community events are trained in PAM and health coverage.	Project		Completed	07/01/2015	10/30/2015	07/01/2015	10/30/2015	12/31/2015	DY1 Q3
Task 2. Develop reporting requirements for CHW placement.	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Use the Care Transitions Strategy developed in 2.a.i. (IDS) including protocols for hospital admission/discharge coordination, care transitions, and communication among primary care, mental health, and substance use providers.	Project		Not Started	10/01/2015	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Deploy PPS resources including multi-disciplinary care coordination teams (developed for project 3.b.i., Disease Management of CVD) and care transition coordinators (identified in Population Health Management).	Project		Not Started	01/01/2016	12/30/2016	07/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 5. Use the referral process (defined under project 3.b.i.) for warm referrals to CBOs and partners, pharmacies, dietitians, and community health workers.	Project		Not Started	01/01/2016	12/30/2016	07/01/2016	12/30/2016	12/31/2016	DY2 Q3
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Project	N/A	In Progress	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task Navigators educated about insurance options and healthcare resources available to populations in this project.	Project		In Progress	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Provide training to community health workers about insurance options and healthcare resources.	Project		Completed	08/03/2015	10/20/2015	08/03/2015	10/20/2015	12/31/2015	DY1 Q3
Task 2. Develop reporting requirements for CHW placement.	Project		Completed	08/03/2015	09/30/2015	08/03/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Monitor placement and make adjustments as appropriate.	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Continue to offer training for community health workers to maintain up-to-date knowledge of changing options and resources.	Project		Not Started	10/01/2015	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #16	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Develop policies and procedures for intake and/or scheduling staff to receive navigator calls.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Work with clinical integration team to improve physicians' understanding of this effort and willingness to provide access.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Initiate PDSA cycles to assess the accessibility of primary and preventive services. Continue to refine policies and procedures as needed.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 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	07/31/2015	03/31/2017	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	07/31/2015	03/31/2017	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Obtain registry lists from MCOs (per requirement #2).	Project		In Progress	07/31/2015	03/18/2016	07/31/2015	03/18/2016	03/31/2016	DY1 Q4
Task 2. CHWs utilize the automated PAM system to record patent encounters.	Project		Completed	09/01/2015	10/30/2015	09/01/2015	10/30/2015	12/31/2015	DY1 Q3
Task 3. CBOs download patient engagement information from PAM on a monthly basis and forward to project champion for quarterly reporting.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Contract or partner with community-based organizations (CBOs) to engage target populations using PAM(R) and other patient										

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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
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 1. Launch community awareness and communication regarding DSRIP. Identify key areas in the north, south, and central areas to hold community forums to bring awareness to DSRIP. Hold community forums throughout the eight counties to provide community education regarding DSRIP.										
Task 2. Work with CBO Task Force to provide outreach and education regarding DSRIP.										
Task 3. Create CBO Implementation Plan.										
Task 4. Select CBOs to serve as PAM vendor(s) via RFQ/RFP process.										
Task 5. Develop materials to support PAM vendors including patient-level reporting tool; train vendors on use of materials/tools.										
Task 6. Host first quarterly meeting with "Voice of the Consumer" Sub-Committee and MCC/PPS team.										
Task 7. Develop and execute contracts with CBOs.										
Task 8. Develop reporting requirements and metrics for each CBO. Continue to monitor metrics throughout project.										
Task 9. Identify a PAM Administrator within each CBO.										
Task 10. For target population Non-Utilizers: Work with DOH to obtain a listing of PAM-eligible non-utilizers; distribute report to CBOs.										
Task 11. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of approach, and allow for continuous improvement over time.										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										

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Millennium Collaborative Care (PPS ID:48)

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 Patient Activation Measure(R) (PAM(R)) training team established.										
Task 1. Establish PPS-wide training team (ensure participation from candidates who represent all of MCC's geographic areas); identify training team goals.										
Task 2. Contact Insignia about conducting PAM training. Resolve the number of Flourish (PAM) licenses across the state.										
Task 3. Develop plan for training (e.g., train the trainer). Plan to offer training in a variety of formats (onsite, web-based, teleconference).										
Task 4. Work with selected CBOs/vendors to identify training participants.										
Task 5. Insignia contract signed.										
Task 6. Develop training materials for community health workers who will be administering PAM.										
Task 7. Identify training locations covering the 8 counties of WNY; schedule training sessions.										
Task 8. Hold first PAM training session for community health workers.										
Task 9. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of training, and allow for continuous improvement over time.										
Task 10. Continue to offer training as needed.										
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 1. Develop hot spot maps; provide maps with zip codes to CBOs that requested the information.										
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
2. For target population Uninsured: Develop plan to outreach to and communicate with the uninsured population.										
Task 3. Promote / focus outreach efforts on target areas including local festivals, fairs, church groups, and the part-time workforce.										
Task 4. Continue conducting outreach.										
Task 5. Develop market share model to understand location and distribution of UI and NU populations.										
Task 6. Develop CBO workforce model to ensure adequate coverage is available to engage the target populations. Engage additional CBOs as necessary (See also Milestone#1).										
Task 7. Collaborate with ED Care Triage project team to include PAM® as appropriate in "hot spot" EDs.										
Task 8. Renew market share model annually and assess progress vs. milestone goals and adjust plan accordingly.										
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 1. Review community needs assessment, and collaborate with CBOs, P2 Collaborative, and county community action plans to update the targeted population's healthcare needs in MCC network.										
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 1. Develop plan for training (e.g., train the trainer). Plan to offer training in a variety of formats (onsite, web-based, teleconference).										
Task 2. Develop a list of targeted providers with the "hot spots" 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
Task 3. Develop communication to providers.										
Task 4. Ensure BAA is in place with all providers.										
Task 5. Develop training material for PPS providers. Obtain state review/approve of any educational materials as required; ensure materials comply with state marketing guidelines and federal regulations as applicable.										
Task 6. Identify training locations covering the 8 counties of WNY; schedule training sessions.										
Task 7. Hold first provider training session.										
Task 8. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of training, and allow for continuous improvement over time.										
Task 9. Continue to offer training 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 1. Work with Independent Health IT security, reporting, and MCO to develop a secure file transfer process and data formats.										

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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 2. Develop and execute a signed BAA addendum with Independent Health MCO.										
Task 3. Receive data from Independent Health.										
Task 4. Match internal PPS attribution reporting (from DOH) against Independent Health data.										
Task 5. Finalize Independent Health report with PAM candidates identified.										
Task 6. Deliver Independent Health Non-Utilizers report to CBOs/vendors.										
Task 7. Receive ongoing Independent Health data feed to support measurement process (refreshed on a quarterly basis).										
Task 8. Work with HealthNow IT security, reporting, and MCO to develop a secure file transfer process and data formats.										
Task 9. Develop and execute a signed BAA addendum with HealthNow MCO.										
Task 10. Receive data from HealthNow.										
Task 11. Match internal PPS attribution reporting (from DOH) against HealthNow data.										
Task 12. Finalize HealthNow report with PAM candidates identified.										
Task 13. Deliver HealthNow Non-Utilizers report to CBOs/vendors.										
Task 14. Receive ongoing HealthNow data feed to support measurement process (refreshed on a quarterly basis).										
Task 15. Work with Fidelis IT security, reporting, and MCO to develop a secure file transfer process and data formats.										
Task 16. Develop and execute a signed BAA addendum with Fidelis MCO.										
Task 17. Receive data from Fidelis.										
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
18. Match internal PPS attribution reporting (from DOH) against Fidelis data.										
Task 19. Finalize Fidelis report with PAM candidates identified.										
Task 20. Deliver Fidelis Non-Utilizers report to CBOs/vendors.										
Task 21. Receive ongoing Fidelis data feed to support measurement process (refreshed on a quarterly basis).										
Task 22. Work with YourCare IT security, reporting, and MCO to develop a secure file transfer process and data formats.										
Task 23. Develop and execute a signed BAA addendum with YourCare MCO.										
Task 24. Receive data from YourCare.										
Task 25. Match internal PPS attribution reporting (from DOH) against YourCare data.										
Task 26. Finalize YourCare report with PAM candidates identified.										
Task 27. Deliver YourCare Non-Utilizers report to CBOs/vendors.										
Task 28. Receive ongoing YourCare data feed to support measurement process (refreshed on a quarterly basis).										
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 1. Complete PAM target goal; determine baseline PAM scores.										
Task 2. Update baseline annually; re-PAM same beneficiaries.										
Task 3. Continue to monitor scores.										
Milestone #8										

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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
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 1. Populate CBO Task Force (as described in Governance requirement #5) by conducting outreach at community forums across PPS region and receiving nominations for CBO representatives. Ensure representation from all eight counties of WNY.										
Task 2. Populate "Voice of the Consumer" Sub-Committee (as described in Governance requirement #5) by conducting outreach at community forums and receiving nominations for Medicaid beneficiaries. Create protocols for engaging PAM beneficiaries in "Voice of the Consumer" Sub-Committee.										
Task 3. "Voice of the Consumer" Sub-Committee will review materials to be presented to beneficiaries to ensure appropriateness of message, evaluate effectiveness, and account for variations in health literacy.										
Task 4. Attend first quarterly CBO Task Force/"Voice of the Consumer" Sub-Committee meeting. Meetings will continue quarterly.										
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										

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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
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 1. Establish protocol for data collection and reporting of screenings and bridges.										
Task 2. Ensure details are included in training program for CBOs.										
Task 3. Establish procedures for obtaining data for quarterly reporting including PAM data by activation level and scoring, clinicians trained, and CBO/CHW evidence of patient bridges established.										
Task 4. Establish procedures for obtaining quarterly refresh of MCO data feeds with visit information (include in report per requirement 10).										
Task 5. Finalize reporting processes and procedures; produce quarterly report.										
Task 6. Continue to refine quarterly reporting process and produce quarterly reports.										
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.										

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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 Volume of non-emergent visits for UI, NU, and LU populations increased.										
Task 1. Obtain quarterly visit info from MCOs based on original target population membership (or from DOH as available); calculate volume of non-emergent visits and report quarterly.										
Task 2. Leverage efforts (Cultural Competency, milestone #1) to improve overall health literacy of targeted populations (e.g., when to use the ED, importance of primary care, overcoming mental health stigma, navigating the health system, and questions to ask your provider).										
Task 3. Develop materials with input from patients. Distribute materials at locations appropriate to the target population (Cultural Competency, milestone #1).										
Task 4. Use public awareness, education, and other programs to address and increase the volume of non-emergent visits in the targeted population groups.										
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	6	10	15	20	21	21	21	21	21
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	0	6	10	15	20	21	21	21	21	21
Task 1. Per the steps defined for requirement #1, ensure CBO contracts are completed and CBOs are engaged.										
Task 2. Continuously monitor CBO performance. Make adjustments to partnerships and/or contracts as needed.										
Task 3. Per tasks in milestones 2, 13, and 15, training for navigators is planned, organized, monitored, and controlled.										
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 1. PPS will research leading practice models to inform development of protocols.										
Task 2. PPS will develop protocols for complaints and customer service to support PPS-wide complaint communication and individual complaint follow-up.										
Task 3. Review protocols with "Voice of the Consumer" Sub-Committee.										
Task 4. Determine process owner and MCC lead.										
Task 5. Determine platform for complaint tracking.										
Task 6. Obtain MCC Board of Managers and PMO approvals.										
Task 7. Implement complaint tracking and follow-up processes.										
Task 8. Initiate PDSA cycles to assess customer satisfaction and allow for continuous improvement over time.										
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	6	10	15	20	21	21	21	21	21
Task 1. Develop plan for training (e.g., train the trainer). Plan to offer training in a variety of formats (onsite, web-based, teleconference).										
Task 2. Identify who is being trained. Create attendee roster.										
Task 3. Develop training material for community navigators.										
Task 4. Identify training locations covering the 8 counties of WNY; schedule training sessions.										
Task 5. Hold first community navigator training sessions. Capture attendee information for subsequent reporting										

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Task 6. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of training, and allow for continuous improvement over time.										
Task 7. Continue to offer training 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	6	10	15	20	21	21	21	21	21
Task 1. Engage CBOs in hot spots who will participate in community events are trained in PAM and health coverage.										
Task 2. Develop reporting requirements for CHW placement.										
Task 3. Use the Care Transitions Strategy developed in 2.a.i. (IDS) including protocols for hospital admission/discharge coordination, care transitions, and communication among primary care, mental health, and substance use providers.										
Task 4. Deploy PPS resources including multi-disciplinary care coordination teams (developed for project 3.b.i., Disease Management of CVD) and care transition coordinators (identified in Population Health Management).										
Task 5. Use the referral process (defined under project 3.b.i.) for warm referrals to CBOs and partners, pharmacies, dietitians, and community health workers.										
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 1. Provide training to community health workers about insurance options and healthcare resources.										
Task 2. Develop reporting requirements for CHW placement.										

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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. Monitor placement and make adjustments as appropriate.										
Task 4. Continue to offer training for community health workers to maintain up-to-date knowledge of changing options and resources.										
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 1. Develop policies and procedures for intake and/or scheduling staff to receive navigator calls.										
Task 2. Work with clinical integration team to improve physicians' understanding of this effort and willingness to provide access.										
Task 3. Initiate PDSA cycles to assess the accessibility of primary and preventive services. Continue to refine policies and procedures as needed.										
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 1. Obtain registry lists from MCOs (per requirement #2).										
Task 2. CHWs utilize the automated PAM system to record patent encounters.										
Task 3. CBOs download patient engagement information from PAM on a monthly basis and forward to project champion for quarterly reporting.										

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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 1. Launch community awareness and communication regarding DSRIP. Identify key areas in the north, south, and central areas to hold community forums to bring awareness to DSRIP. Hold community forums throughout the eight counties to provide community education regarding DSRIP.										
Task 2. Work with CBO Task Force to provide outreach and education regarding DSRIP.										
Task 3. Create CBO Implementation Plan.										
Task 4. Select CBOs to serve as PAM vendor(s) via RFQ/RFP process.										
Task 5. Develop materials to support PAM vendors including patient-level reporting tool; train vendors on use of materials/tools.										
Task 6. Host first quarterly meeting with "Voice of the Consumer" Sub-Committee and MCC/PPS team.										
Task 7. Develop and execute contracts with CBOs.										
Task 8. Develop reporting requirements and metrics for each CBO. Continue to monitor metrics throughout project.										
Task 9. Identify a PAM Administrator within each CBO.										
Task 10. For target population Non-Utilizers: Work with DOH to obtain a listing of PAM-eligible non-utilizers; distribute report to CBOs.										
Task 11. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of approach, and allow for continuous improvement over time.										
Milestone #2										

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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 1. Establish PPS-wide training team (ensure participation from candidates who represent all of MCC's geographic areas); identify training team goals.										
Task 2. Contact Insignia about conducting PAM training. Resolve the number of Flourish (PAM) licenses across the state.										
Task 3. Develop plan for training (e.g., train the trainer). Plan to offer training in a variety of formats (onsite, web-based, teleconference).										
Task 4. Work with selected CBOs/vendors to identify training participants.										
Task 5. Insignia contract signed.										
Task 6. Develop training materials for community health workers who will be administering PAM.										
Task 7. Identify training locations covering the 8 counties of WNY; schedule training sessions.										
Task 8. Hold first PAM training session for community health workers.										
Task 9. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of training, and allow for continuous improvement over time.										
Task 10. Continue to offer training as needed.										
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										

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1. Develop hot spot maps; provide maps with zip codes to CBOs that requested the information.										
Task 2. For target population Uninsured: Develop plan to outreach to and communicate with the uninsured population.										
Task 3. Promote / focus outreach efforts on target areas including local festivals, fairs, church groups, and the part-time workforce.										
Task 4. Continue conducting outreach.										
Task 5. Develop market share model to understand location and distribution of UI and NU populations.										
Task 6. Develop CBO workforce model to ensure adequate coverage is available to engage the target populations. Engage additional CBOs as necessary (See also Milestone#1).										
Task 7. Collaborate with ED Care Triage project team to include PAM® as appropriate in "hot spot" EDs.										
Task 8. Renew market share model annually and assess progress vs. milestone goals and adjust plan accordingly.										
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 1. Review community needs assessment, and collaborate with CBOs, P2 Collaborative, and county community action plans to update the targeted population's healthcare needs in MCC network.										
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 1. Develop plan for training (e.g., train the trainer). Plan to offer training in a variety of formats (onsite, web-based,										

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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
teleconference).										
Task 2. Develop a list of targeted providers with the "hot spots" areas.										
Task 3. Develop communication to providers.										
Task 4. Ensure BAA is in place with all providers.										
Task 5. Develop training material for PPS providers. Obtain state review/approve of any educational materials as required; ensure materials comply with state marketing guidelines and federal regulations as applicable.										
Task 6. Identify training locations covering the 8 counties of WNY; schedule training sessions.										
Task 7. Hold first provider training session.										
Task 8. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of training, and allow for continuous improvement over time.										
Task 9. Continue to offer training 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.										

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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. Work with Independent Health IT security, reporting, and MCO to develop a secure file transfer process and data formats.										
Task 2. Develop and execute a signed BAA addendum with Independent Health MCO.										
Task 3. Receive data from Independent Health.										
Task 4. Match internal PPS attribution reporting (from DOH) against Independent Health data.										
Task 5. Finalize Independent Health report with PAM candidates identified.										
Task 6. Deliver Independent Health Non-Utilizers report to CBOs/vendors.										
Task 7. Receive ongoing Independent Health data feed to support measurement process (refreshed on a quarterly basis).										
Task 8. Work with HealthNow IT security, reporting, and MCO to develop a secure file transfer process and data formats.										
Task 9. Develop and execute a signed BAA addendum with HealthNow MCO.										
Task 10. Receive data from HealthNow.										
Task 11. Match internal PPS attribution reporting (from DOH) against HealthNow data.										
Task 12. Finalize HealthNow report with PAM candidates identified.										
Task 13. Deliver HealthNow Non-Utilizers report to CBOs/vendors.										
Task 14. Receive ongoing HealthNow data feed to support measurement process (refreshed on a quarterly basis).										
Task 15. Work with Fidelis IT security, reporting, and MCO to develop a secure file transfer process and data formats.										
Task 16. Develop and execute a signed BAA addendum with Fidelis MCO.										

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Millennium Collaborative Care (PPS ID:48)

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 17. Receive data from Fidelis.										
Task 18. Match internal PPS attribution reporting (from DOH) against Fidelis data.										
Task 19. Finalize Fidelis report with PAM candidates identified.										
Task 20. Deliver Fidelis Non-Utilizers report to CBOs/vendors.										
Task 21. Receive ongoing Fidelis data feed to support measurement process (refreshed on a quarterly basis).										
Task 22. Work with YourCare IT security, reporting, and MCO to develop a secure file transfer process and data formats.										
Task 23. Develop and execute a signed BAA addendum with YourCare MCO.										
Task 24. Receive data from YourCare.										
Task 25. Match internal PPS attribution reporting (from DOH) against YourCare data.										
Task 26. Finalize YourCare report with PAM candidates identified.										
Task 27. Deliver YourCare Non-Utilizers report to CBOs/vendors.										
Task 28. Receive ongoing YourCare data feed to support measurement process (refreshed on a quarterly basis).										
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 1. Complete PAM target goal; determine baseline PAM scores.										
Task 2. Update baseline annually; re-PAM same 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 3. Continue to monitor scores.										
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 1. Populate CBO Task Force (as described in Governance requirement #5) by conducting outreach at community forums across PPS region and receiving nominations for CBO representatives. Ensure representation from all eight counties of WNY.										
Task 2. Populate "Voice of the Consumer" Sub-Committee (as described in Governance requirement #5) by conducting outreach at community forums and receiving nominations for Medicaid beneficiaries. Create protocols for engaging PAM beneficiaries in "Voice of the Consumer" Sub-Committee.										
Task 3. "Voice of the Consumer" Sub-Committee will review materials to be presented to beneficiaries to ensure appropriateness of message, evaluate effectiveness, and account for variations in health literacy.										
Task 4. Attend first quarterly CBO Task Force/"Voice of the Consumer" Sub-Committee meeting. Meetings will continue quarterly.										
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										

Millennium Collaborative Care (PPS ID:48)

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
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 1. Establish protocol for data collection and reporting of screenings and bridges.										
Task 2. Ensure details are included in training program for CBOs.										
Task 3. Establish procedures for obtaining data for quarterly reporting including PAM data by activation level and scoring, clinicians trained, and CBO/CHW evidence of patient bridges established.										
Task 4. Establish procedures for obtaining quarterly refresh of MCO data feeds with visit information (include in report per requirement 10).										
Task 5. Finalize reporting processes and procedures; produce quarterly report.										
Task 6. Continue to refine quarterly reporting process and produce quarterly reports.										

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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 #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 1. Obtain quarterly visit info from MCOs based on original target population membership (or from DOH as available); calculate volume of non-emergent visits and report quarterly.										
Task 2. Leverage efforts (Cultural Competency, milestone #1) to improve overall health literacy of targeted populations (e.g., when to use the ED, importance of primary care, overcoming mental health stigma, navigating the health system, and questions to ask your provider).										
Task 3. Develop materials with input from patients. Distribute materials at locations appropriate to the target population (Cultural Competency, milestone #1).										
Task 4. Use public awareness, education, and other programs to address and increase the volume of non-emergent visits in the targeted population groups.										
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.	21	21	21	21	21	21	21	21	21	21
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	21	21	21	21	21	21	21	21	21	21
Task 1. Per the steps defined for requirement #1, ensure CBO contracts are completed and CBOs are engaged.										
Task 2. Continuously monitor CBO performance. Make adjustments to partnerships and/or contracts as needed.										
Task 3. Per tasks in milestones 2, 13, and 15, training for navigators is planned, organized, monitored, and controlled.										

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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 #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.										
Task Policies and procedures for customer service complaints and appeals developed.										
Task 1. PPS will research leading practice models to inform development of protocols.										
Task 2. PPS will develop protocols for complaints and customer service to support PPS-wide complaint communication and individual complaint follow-up.										
Task 3. Review protocols with "Voice of the Consumer" Sub-Committee.										
Task 4. Determine process owner and MCC lead.										
Task 5. Determine platform for complaint tracking.										
Task 6. Obtain MCC Board of Managers and PMO approvals.										
Task 7. Implement complaint tracking and follow-up processes.										
Task 8. Initiate PDSA cycles to assess customer satisfaction and allow for continuous improvement over time.										
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).	21	21	21	21	21	21	21	21	21	21
Task 1. Develop plan for training (e.g., train the trainer). Plan to offer training in a variety of formats (onsite, web-based, teleconference).										
Task 2. Identify who is being trained. Create attendee roster.										
Task 3. Develop training material for community navigators.										
Task 4. Identify training locations covering the 8 counties of WNY; schedule training sessions.										

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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. Hold first community navigator training sessions. Capture attendee information for subsequent reporting										
Task 6. Initiate PDSA cycles to evaluate improvement activities, determine effectiveness of training, and allow for continuous improvement over time.										
Task 7. Continue to offer training 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.	21	21	21	21	21	21	21	21	21	21
Task 1. Engage CBOs in hot spots who will participate in community events are trained in PAM and health coverage.										
Task 2. Develop reporting requirements for CHW placement.										
Task 3. Use the Care Transitions Strategy developed in 2.a.i. (IDS) including protocols for hospital admission/discharge coordination, care transitions, and communication among primary care, mental health, and substance use providers.										
Task 4. Deploy PPS resources including multi-disciplinary care coordination teams (developed for project 3.b.i., Disease Management of CVD) and care transition coordinators (identified in Population Health Management).										
Task 5. Use the referral process (defined under project 3.b.i.) for warm referrals to CBOs and partners, pharmacies, dietitians, and community health workers.										
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 1. Provide training to community health workers about insurance										

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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
options and healthcare resources.										
Task 2. Develop reporting requirements for CHW placement.										
Task 3. Monitor placement and make adjustments as appropriate.										
Task 4. Continue to offer training for community health workers to maintain up-to-date knowledge of changing options and resources.										
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 1. Develop policies and procedures for intake and/or scheduling staff to receive navigator calls.										
Task 2. Work with clinical integration team to improve physicians' understanding of this effort and willingness to provide access.										
Task 3. Initiate PDSA cycles to assess the accessibility of primary and preventive services. Continue to refine policies and procedures as needed.										
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 1. Obtain registry lists from MCOs (per requirement #2).										
Task 2. CHWs utilize the automated PAM system to record patent encounters.										
Task 3. CBOs download patient engagement information from PAM on a monthly basis and forward to project champion for quarterly reporting.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	Tasks #1-9 were completed; the schedule for task #7 was adjusted with no impact to other tasks.
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Tasks #1-8 were completed on schedule; in-progress tasks are on track.
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.	Tasks #1, 2, 5, 6 completed on schedule; in-progress tasks are on track.
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.	Task #1, 2 & 5 were completed on schedule; schedules for 3, 4, 6, & 7 have been adjusted with no anticipated impact on overall milestone dates.
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.	Tasks #1-3 and 8-10 were completed on schedule; the schedule for tasks #6 and #13 was adjusted. Tasks #4, 5, 11, 12 were determined to be unnecessary. Other in-progress tasks on schedule.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	In-progress tasks are on track.
Include beneficiaries in development team to promote preventive care.	Tasks #1-2 were completed on schedule; in-progress tasks are on track.
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.	Tasks #1-3 and 5 were completed on schedule; the schedule for task #4 was adjusted with no anticipated impact to milestone dates. In-progress tasks are on track.
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,	Task #1 was completed on schedule; in-progress tasks are on track.

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
community healthcare resources (including for primary and preventive services) and patient education.	
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Tasks #1-6 were completed on schedule.
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Tasks #1-5 were completed on schedule; in-progress tasks are on track.
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.	Tasks #1-2 were completed on schedule; schedules for remaining tasks have been adjusted with no anticipated impact on milestone dates.
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Tasks #1-2 were completed on schedule; schedule for remaining tasks was adjusted with no anticipated impact to milestone dates.
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Schedule for task #1 adjusted; in-progress tasks are on track.
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 #2 was completed on schedule; in-progress tasks are on track.

Milestone Review Status

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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IPQR Module 2.d.i.5 - IA Monitoring

Instructions :

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

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

Instructions :

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

Many programs have shown that integration of behavioral health (BH) and primary care (PC) services improves quality of care and decreases total cost of care. However, there are many risks associated with the implementation of these programs. MCC has identified these risks and some mitigation strategies below.

Financial challenges exist to achieve the goals to embed BH specialists into safety net PC practices and PC into BH sites. Millennium will help ease this financial burden by facilitating the use of shared therapists and psychiatric providers among multiple PC sites. Instruction on how to properly bill for services, while ensuring adequate funding is in place to support outcomes. Exploring satellite MH/CD clinics embedded into PC practices so both Medicaid and commercial insurance can be billed, or enhanced rapid access referral process from PMC to BH clinics will also be implemented. Through a value-based payment (VBP) transition plan, MCC will prioritize the planning/execution of agreements to ensure that integration of PC and BH services does not simply become co-location.

PC practices are unfamiliar with BH services and support and vice-versa. In addition, staff turnover and shortage are common concerns. MCC will provide technical assistance and financial support utilizing a staffing plan to incorporate shared coverage across sites and telemedicine to stretch available resources. Failure to build bridges with area colleges could result in longer-term gaps in availability of BH professionals. MCC's workforce development plan will incorporate short and long-term strategies to fill gaps.

Limited access to psychiatric services exist in our region and hinders the ability of providers to acquire consultations/medication recommendations for patients in need of services. BH organizations, private practice psychiatry, and PC practices will meet to discuss tele-medicine services to fulfill this need. If telemedicine is not feasible, agreements for phone consultations, rapid access referrals, and exchange of information through EMR and the RHIO will be established.

Regulatory barriers may restrict or prohibit provision of PC services within BH settings and vice versa. MCC will review basic requirements to be achieved and identify regulations that need to be changed so services can be offered in a shared setting and remain reimbursable.

BH clients not connected to PC may be reluctant, therefore MCC will offer trainings in Motivational Interviewing, Patient Activation Measures, and person-centered approach to ensure client engagement.

Exchange of information across physical and mental health disciplines is lacking. MCC will work with partners to incorporate a multidisciplinary approach to case conferences sessions; warm hand-offs, and other strategies. This coordinated approach is necessary to address the high-risk BH population, and will help provide a uniform experience for patients regardless of where they receive care. Close coordination with bordering PPSs will include standardized referral protocols, uniform tracking/reporting systems, universal alert messaging via the RHIO, common

messaging, and sharing of lessons learned.

Protocols for integrated service delivery/reporting may differ from one PPS to another. MCC will work with bordering PPS's to institute policies for identifying PCPs participating in more than one PPS, and to standardize protocols for consistent reporting. True service integration is dependent upon integration of client records so providers take a holistic approach to client care. MCC's IT program will develop interim plans to achieve this standard.

Laboratory collection services may not be available onsite at PC offices requiring clients to be referred for testing. MCC will explore opportunities for incorporating lab testing and educational materials at participating sites.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	22,700

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
2,473	4,516	90.32%	484	19.89%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (5,000)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ethelen	Baseline or Performance Documentation	48_PMDL3715_1_3_20160202182959_3ai_PE_registry_DY1Q3.xlsx	Patient engagement registry showing 2,043 patient engaged in Q3	02/02/2016 06:30 PM

Narrative Text :

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

patients previously reported in DY1 Q2: 2,473. new patients engaged in DY1 Q3: 2,043. cumulative total: 4,516

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Model 1	Project	N/A	In Progress	07/01/2015	03/30/2018	07/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/30/2018	07/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	07/01/2015	03/30/2018	07/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task 1. Establish a master list of primary care (PC) sites interested in the project (602 sites are listed in the application).		Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 2. Establish a master list of behavioral health (BH) providers interested in the project (165 providers are listed in the application).		Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Identify with Community Partners of WNY (CPWNY, led by Catholic Medical Partners) which PC and BH care providers are in both PPSs.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Have PC and BH care site partners sign agreements or letters of intent indicating commitment to program.		Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Survey (such as a Survey Monkey or similar tool) sent to participating PC and BH sites asking PCMH status, NCQA		Project		Completed	07/01/2015	03/31/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Millennium Collaborative Care (PPS ID:48)

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
level, percent of Medicaid patients served, EHR status and vendor, CCD capacity to send and receive records, use of RHIO, capacity, usage of screening instruments, etc. This survey will be coordinated with the current state assessment performed under project 2.a.i. (IDS).										
Task 6. Collaborate with CPWNY where there is overlap with PC and/or BH Sites.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7. Leverage Clinical Integration Needs Assessment of participating partners to assess current experience with satellite clinic integration and willingness to consider, EHR status, RHIO relationship, capacity to send/receive records, use of screenings, etc.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8. MCC and CPWNY staff jointly determine if the restrictions on integrating Article 31 clinics into Article 28 OP PC sites are DOH or Federal regulations. Seek regulatory waiver; if waiver not feasible, asses feasibility of Article 28 clinics of hiring own BH staff.		Project		In Progress	08/31/2015	03/31/2016	08/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9. Organize and convene the first of several monthly workgroup meetings of Behavioral Health and Primary Care Programs of WNY counties (meeting and phone-in option), led by teams of physician, BH leader, MCC, and CPWNY representatives.		Project		Completed	08/01/2015	03/31/2017	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 10. Continue to meet with key stakeholders at regular intervals (bi-monthly) for those identified as ready to implement integrated model based on survey and meeting information.		Project		In Progress	08/01/2015	03/29/2018	08/01/2015	03/29/2018	03/31/2018	DY3 Q4
Task 11. Perform hot spotting analysis of current practices delivered in the eight WNY counties and gaps in services for the region and evaluate the gaps.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 12. Coordinate messaging and communication strategy		Project		In Progress	08/01/2015	12/31/2015	08/01/2015	03/30/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
with MCC Communications Director and CPWNY to engage PC sites unsure of participation.										
Task 13. Evaluate budget of project to support gaps in service.		Project		In Progress	12/31/2015	01/29/2016	12/31/2015	01/29/2016	03/31/2016	DY1 Q4
Task 14. Ongoing communication and collaboration with MCC management and 2ai project director, who are working to establish PCMH/MU project implementation plan based on PC practice readiness, certification status, and related activities as referenced in 2.a.i. Requirement #7.		Project		In Progress	07/01/2015	03/30/2018	07/01/2015	03/30/2018	03/31/2018	DY3 Q4
Task 15. In collaboration with MCC Management and 2ai project director, analyze current status of EMR systems as outlined in 2.a.i. Requirement #7.		Project		In Progress	07/27/2015	03/31/2016	07/27/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task 1. Investigate various collaborative care models, review SAMHSA best practices, and arrange phone meetings with experts at University of Washington AIMS Center.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Work with MCC Clinical Director, Chief Medical Officer (CMO) and Clinical Quality Committee with sign-off by the Physician Steering Committee (PSC) to devise protocols utilizing chosen evidence-based standards in regards to care management protocols such as warm hand-offs.		Project		In Progress	08/03/2015	06/30/2016	08/03/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Coordinate care management protocols with CPWNY,		Project		In Progress	08/28/2015	03/29/2017	08/28/2015	03/29/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
where applicable to ensure that services across the eight WNY counties are provided under one set of evidence-based standards.										
Task 4. Begin to convene monthly provider stakeholder meetings with BH and PC partners; share ideas and provide feedback back to CMO.		Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Draft final plan with MCC Clinical Director, CMO, and CPWNY partners where applicable and share with key stakeholders for feedback.		Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6. Finalize implementation plan with partners.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7. Project manager will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve (where necessary) the established evidence-based protocols that support integrated treatment and practice.		Project		In Progress	10/01/2015	03/29/2017	10/01/2015	03/29/2017	03/31/2017	DY2 Q4
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	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Screenings are documented in Electronic Health Record.		Project		In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
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	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	09/30/2017	07/01/2015	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Electronic Health Record.										
Task 1. PC and BH practices jointly surveyed by MCC and CPWNY, where applicable to assess which preventive screenings are currently being implemented routinely for patients in both PC and BH practices.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. MCC 2ai team to identify best practice physical health preventive care screenings to be adopted by PCPs and BH practices.		Project		Completed	08/01/2015	09/30/2016	08/01/2015	10/01/2015	12/31/2015	DY1 Q3
Task 3. Develop a training plan for PC and BH practices to support adoption of best practice screenings where there are current gaps in identified PCPs and BH providers. Training plan includes educating practices on the billing codes for PHQ-9 and SBIRT screens (many practices are unaware of ability to bill for these screens, and absence of billing is a barrier).		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. MCC clinical integration teams provides training to PCPs and BH providers.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Ensure PHQ9, SBIRT, or other behavioral health screenings are documented in participating provider EMRs.		Project		In Progress	09/01/2015	09/30/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 6. Clinical integration training teams (with CPWNY counterparts for joint PPS membership) incorporate reviews of screening protocols and implementation with quarterly technical assistance meetings with providers.		Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
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	03/29/2017	07/01/2015	03/29/2017	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	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
engaged patients for project milestone reporting.										
Task 1. Ongoing communication and collaboration with MCC management and 2.a.i. project team who are working to establish PCMH/MU project implementation plan including EHR requirement.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task 2. Information will be shared monthly at BH and PCP stakeholder meetings.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task 3. Project manager or designee will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve where necessary.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task 4. Collaborate with 2.a.i. clinical integration team and IT Data Committee to discuss any issues and to brainstorm and problem-solve any shared data issues.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health sites.	Model 2	Project	N/A	In Progress	07/01/2015	03/29/2018	07/01/2015	03/29/2018	03/31/2018	DY3 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/29/2018	07/01/2015	03/29/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/29/2018	07/01/2015	03/29/2018	03/31/2018	DY3 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	In Progress	07/01/2015	03/29/2018	07/01/2015	03/29/2018	03/31/2018	DY3 Q4
Task 1. Establish a master list of PC sites interested in the project (602 sites are listed in the application).		Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Establish a master list of BH providers interested in the project (165 providers are listed in the application).		Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Identify with CPWNY which PC and BH care providers are in both PPSs.		Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3

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Task 4. Have PC and BH care site partners sign agreements or letters of intent indicating commitment to program.		Project		Completed	07/01/2015	03/31/2016	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Survey (such as a Survey Monkey or similar tool) sent to participating PC and BH sites asking PCMH status, NCQA level, percent of Medicaid patients served, EHR status and vendor, CCD capacity to send and receive records, use of RHIO, capacity, usage of screening instruments, etc. This survey will be coordinated with the current state assessment performed under project 2.a.i. (IDS).		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6. Collaborate with CPWNY where there is overlap with PC and/or BH sites.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7. Leverage Clinical Integration Needs Assessment of participating partners to assess current experience with satellite clinic integration and willingness to consider, EHR status, RHIO relationship, capacity to send/receive records, use of screenings, etc.		Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8. Participating providers will assess and report to MCC on their status in regards to site readiness, regulatory issues (if applicable), and billing issues.		Project		In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 9. Ensure primary care providers are culturally sensitive and aware of issues that may make clients reluctant to seek healthcare outside of the behavioral health setting. Link providers to cultural competency/health literacy trainings coordinated by the PPS.		Project		In Progress	07/01/2015	12/31/2017	07/01/2015	12/31/2017	12/31/2017	DY3 Q3
Task 10. Organize and convene the first of several monthly work group of Behavioral Health and Primary Care Programs of WNY counties (meeting and phone-in option). Led by teams of physicians, BH leaders, MCC, and CPWNY representatives.		Project		In Progress	08/31/2015	03/31/2017	08/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	08/01/2015	03/29/2018	08/01/2015	03/29/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
11. Continue to meet with key stakeholders at regular intervals (bi-monthly) for those identified as ready to implement integrated model based on survey and meeting information.										
Task 12. Perform hot spotting analysis of current practices delivered in the eight WNY counties and gaps in services for the region and evaluate the gaps.		Project		In Progress	07/01/2015	12/31/2015	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 13. Coordinate messaging and communication strategy with MCC Communications Director and CPWNY to engage PC sites unsure of participation.		Project		In Progress	12/31/2015	03/29/2016	12/31/2015	03/29/2016	03/31/2016	DY1 Q4
Task 14. Evaluate budget of project to support gaps in service.		Project		In Progress	12/31/2015	01/29/2016	12/31/2015	01/29/2016	03/31/2016	DY1 Q4
Task 15. Ongoing communication and collaboration with MCC management and 2.a.i. project director, who are working to establish PCMH/MU project implementation plan based on PC practice readiness, certification status, and related activities as referenced in 2.a.i. Requirement #7.		Project		In Progress	07/01/2015	01/29/2016	07/01/2015	01/29/2016	03/31/2016	DY1 Q4
Task 16. In collaboration with MCC Management and 2a.i. project director, analyze current status of EMR systems as outlined in 2.a.i. Requirement #7.		Project		In Progress	07/27/2015	03/31/2016	07/27/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	In Progress	07/13/2015	03/31/2017	07/13/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	07/13/2015	03/31/2017	07/13/2015	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	07/13/2015	03/31/2017	07/13/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Investigate various evidence-based models, review		Project		Completed	07/13/2015	12/31/2015	07/13/2015	12/31/2015	12/31/2015	DY1 Q3

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
SAMHSA best practices, and arrange phone meetings with experts and vendors for telepsychiatry services.										
Task 2. Work with MCC Clinical Director, Chief Medical Officer (CMO) and Clinical Quality Committee with sign-off by the Physician Steering Committee (PSC) to devise protocols utilizing chosen evidence-based standards in regards to care management protocols such as warm hand-offs.		Project		In Progress	08/03/2015	06/30/2016	08/03/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Coordinate care management protocols with CPWNY, where applicable to ensure that services across the eight WNY counties are provided under one set of evidence-based standards.		Project		In Progress	08/28/2015	03/29/2017	08/28/2015	03/29/2017	03/31/2017	DY2 Q4
Task 4. PC partners; share ideas and provide feedback back to CMO.		Project		Completed	08/01/2015	12/31/2015	08/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 5. Draft final plan with MCC Clinical Director, CMO, and CPWNY partners where applicable and share with key stakeholders for feedback.		Project		In Progress	09/01/2015	03/29/2016	09/01/2015	03/29/2016	03/31/2016	DY1 Q4
Task 6. Finalize implementation plan with partners.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7. Project manager will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve (where necessary) the established evidence-based protocols that support integrated treatment and practice.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Model 2	Project	N/A	In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		In Progress	07/01/2015	09/30/2017	07/01/2015	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task Screenings are documented in Electronic Health Record.		Project		In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
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	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. PC and BH practices jointly surveyed by MCC and CPWNY, where applicable to assess which preventive screenings are currently being implemented routinely for patients in both PC and BH practices.		Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. MCC 2ai team to identify best practice physical health preventive care screenings to be adopted by BH providers across and PC practices.		Project		In Progress	08/01/2015	09/30/2016	08/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Develop a training plan for PC and BH practices to support adoption of best practice screenings where there are current gaps in identified PCPs and BH providers. Training plan includes educating practices on the billing codes for PHQ-9 and SBIRT screens (many practices are unaware of ability to bill for these screens, and absence of billing is a barrier).		Project		In Progress	09/01/2015	09/30/2016	09/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 4. MCC clinical integration teams provides training to PCPs and BH providers PPSs.		Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Ensure PHQ-9, SBIRT, or other behavioral health screenings are documented in participating provider EMRs.		Project		In Progress	09/01/2015	09/30/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task 6. Clinical integration training teams (with CPWNY counterparts for joint PPS membership) incorporate		Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2

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reviews of screening protocols and implementation with quarterly technical assistance meetings with providers.										
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	03/29/2017	07/01/2015	03/29/2017	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	03/29/2017	07/01/2015	03/29/2017	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	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task 1. Ongoing communication and collaboration with MCC management and 2.a.i. project team manager who are working to establish PCMH/MU project implementation plan including EHR requirement.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task 2. Information will be shared monthly at BH and PCP stakeholder meetings.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task 3. Project manager or designee will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve where necessary.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Task 4. Collaborate with 2.a.i. clinical integration team and IT Data Committee to discuss any issues and to brainstorm and problem-solve any shared data issues.		Project		In Progress	07/01/2015	03/29/2017	07/01/2015	03/29/2017	03/31/2017	DY2 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Model 3	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task		Project		On Hold	04/01/2015	03/31/2020	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.		Project		On Hold	04/01/2015	03/31/2020	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	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	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	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	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	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	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	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes		Project		On Hold	04/01/2015	03/31/2020	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	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	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	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	2	5	10	15	27	52	92	510	602
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	2	6	10	15	22	40	70	100	165
Task 1. Establish a master list of primary care (PC) sites interested in the project (602 sites are listed in the application).										
Task 2. Establish a master list of behavioral health (BH) providers interested in the project (165 providers are listed in the application).										
Task 3. Identify with Community Partners of WNY (CPWNY, led by Catholic Medical Partners) which PC and BH care providers are in both PPSs.										
Task 4. Have PC and BH care site partners sign agreements or letters of intent indicating commitment to program.										

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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. Survey (such as a Survey Monkey or similar tool) sent to participating PC and BH sites asking PCMH status, NCQA level, percent of Medicaid patients served, EHR status and vendor, CCD capacity to send and receive records, use of RHIO, capacity, usage of screening instruments, etc. This survey will be coordinated with the current state assessment performed under project 2.a.i. (IDS).										
Task 6. Collaborate with CPWNY where there is overlap with PC and/or BH Sites.										
Task 7. Leverage Clinical Integration Needs Assessment of participating partners to assess current experience with satellite clinic integration and willingness to consider, EHR status, RHIO relationship, capacity to send/receive records, use of screenings, etc.										
Task 8. MCC and CPWNY staff jointly determine if the restrictions on integrating Article 31 clinics into Article 28 OP PC sites are DOH or Federal regulations. Seek regulatory waiver; if waiver not feasible, asses feasibility of Article 28 clinics of hiring own BH staff.										
Task 9. Organize and convene the first of several monthly workgroup meetings of Behavioral Health and Primary Care Programs of WNY counties (meeting and phone-in option), led by teams of physician, BH leader, MCC, and CPWNY representatives.										
Task 10. Continue to meet with key stakeholders at regular intervals (bi-monthly) for those identified as ready to implement integrated model based on survey and meeting information.										
Task 11. Perform hot spotting analysis of current practices delivered in the eight WNY counties and gaps in services for the region and evaluate the gaps.										
Task 12. Coordinate messaging and communication strategy with MCC Communications Director and CPWNY to engage PC sites unsure of participation.										
Task 13. Evaluate budget of project to support gaps in service.										
Task 14. Ongoing communication and collaboration with MCC management and 2ai project director, who are working 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
establish PCMH/MU project implementation plan based on PC practice readiness, certification status, and related activities as referenced in 2.a.i. Requirement #7.										
Task 15. In collaboration with MCC Management and 2ai project director, analyze current status of EMR systems as outlined in 2.a.i. Requirement #7.										
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. Investigate various collaborative care models, review SAMHSA best practices, and arrange phone meetings with experts at University of Washington AIMS Center.										
Task 2. Work with MCC Clinical Director, Chief Medical Officer (CMO) and Clinical Quality Committee with sign-off by the Physician Steering Committee (PSC) to devise protocols utilizing chosen evidence-based standards in regards to care management protocols such as warm hand-offs.										
Task 3. Coordinate care management protocols with CPWNY, where applicable to ensure that services across the eight WNY counties are provided under one set of evidence-based standards.										
Task 4. Begin to convene monthly provider stakeholder meetings with BH and PC partners; share ideas and provide feedback back to CMO.										
Task 5. Draft final plan with MCC Clinical Director, CMO, and CPWNY partners where applicable and share with key stakeholders for feedback.										
Task 6. Finalize implementation plan with partners.										
Task 7. Project manager will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-										

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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
solve (where necessary) the established evidence-based protocols that support integrated treatment and practice.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	2	5	10	15	27	52	92	510	602
Task 1. PC and BH practices jointly surveyed by MCC and CPWNY, where applicable to assess which preventive screenings are currently being implemented routinely for patients in both PC and BH practices.										
Task 2. MCC 2ai team to identify best practice physical health preventive care screenings to be adopted by PCPs and BH practices.										
Task 3. Develop a training plan for PC and BH practices to support adoption of best practice screenings where there are current gaps in identified PCPs and BH providers. Training plan includes educating practices on the billing codes for PHQ-9 and SBIRT screens (many practices are unaware of ability to bill for these screens, and absence of billing is a barrier).										
Task 4. MCC clinical integration teams provides training to PCPs and BH providers.										
Task 5. Ensure PHQ9, SBIRT, or other behavioral health screenings are documented in participating provider EMRs.										
Task 6. Clinical integration training teams (with CPWNY counterparts for joint PPS membership) incorporate reviews of screening										

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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
protocols and implementation with quarterly technical assistance meetings with providers.										
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. Ongoing communication and collaboration with MCC management and 2.a.i. project team who are working to establish PCMH/MU project implementation plan including EHR requirement.										
Task 2. Information will be shared monthly at BH and PCP stakeholder meetings.										
Task 3. Project manager or designee will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve where necessary.										
Task 4. Collaborate with 2.a.i. clinical integration team and IT Data Committee to discuss any issues and to brainstorm and problem-solve any shared data issues.										
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	2	5	10	15	27	52	92	510	602
Task Primary care services are co-located within behavioral Health practices and are available.	0	2	5	10	15	27	52	92	510	602
Task Primary care services are co-located within behavioral Health practices and are available.	0	2	6	10	15	22	40	70	100	165
Task 1. Establish a master list of PC sites interested in the project (602 sites are listed in the application).										
Task 2. Establish a master list of BH providers interested in the project (165 providers are listed in the application).										

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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. Identify with CPWNY which PC and BH care providers are in both PPSs.										
Task 4. Have PC and BH care site partners sign agreements or letters of intent indicating commitment to program.										
Task 5. Survey (such as a Survey Monkey or similar tool) sent to participating PC and BH sites asking PCMH status, NCQA level, percent of Medicaid patients served, EHR status and vendor, CCD capacity to send and receive records, use of RHIO, capacity, usage of screening instruments, etc. This survey will be coordinated with the current state assessment performed under project 2.a.i. (IDS).										
Task 6. Collaborate with CPWNY where there is overlap with PC and/or BH sites.										
Task 7. Leverage Clinical Integration Needs Assessment of participating partners to assess current experience with satellite clinic integration and willingness to consider, EHR status, RHIO relationship, capacity to send/receive records, use of screenings, etc.										
Task 8. Participating providers will assess and report to MCC on their status in regards to site readiness, regulatory issues (if applicable), and billing issues.										
Task 9. Ensure primary care providers are culturally sensitive and aware of issues that may make clients reluctant to seek healthcare outside of the behavioral health setting. Link providers to cultural competency/health literacy trainings coordinated by the PPS.										
Task 10. Organize and convene the first of several monthly work group of Behavioral Health and Primary Care Programs of WNY counties (meeting and phone-in option). Led by teams of physicians, BH leaders, MCC, and CPWNY representatives.										
Task 11. Continue to meet with key stakeholders at regular intervals (bi-monthly) for those identified as ready to implement integrated model based on survey and meeting information.										
Task 12. Perform hot spotting analysis of current practices delivered in the eight WNY counties and gaps in services for the region 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
evaluate the gaps.										
Task 13. Coordinate messaging and communication strategy with MCC Communications Director and CPWNY to engage PC sites unsure of participation.										
Task 14. Evaluate budget of project to support gaps in service.										
Task 15. Ongoing communication and collaboration with MCC management and 2.a.i. project director, who are working to establish PCMH/MU project implementation plan based on PC practice readiness, certification status, and related activities as referenced in 2.a.i. Requirement #7.										
Task 16. In collaboration with MCC Management and 2a.i. project director, analyze current status of EMR systems as outlined in 2.a.i. Requirement #7.										
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. Investigate various evidence-based models, review SAMHSA best practices, and arrange phone meetings with experts and vendors for telepsychiatry services.										
Task 2. Work with MCC Clinical Director, Chief Medical Officer (CMO) and Clinical Quality Committee with sign-off by the Physician Steering Committee (PSC) to devise protocols utilizing chosen evidence-based standards in regards to care management protocols such as warm hand-offs.										
Task 3. Coordinate care management protocols with CPWNY, where applicable to ensure that services across the eight WNY counties are provided under one set of evidence-based standards.										
Task 4. PC partners; share ideas and provide feedback back to CMO.										

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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. Draft final plan with MCC Clinical Director, CMO, and CPWNY partners where applicable and share with key stakeholders for feedback.										
Task 6. Finalize implementation plan with partners.										
Task 7. Project manager will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve (where necessary) the established evidence-based protocols that support integrated treatment and practice.										
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.	0	2	5	10	15	27	52	92	510	602
Task 1. PC and BH practices jointly surveyed by MCC and CPWNY, where applicable to assess which preventive screenings are currently being implemented routinely for patients in both PC and BH practices.										
Task 2. MCC 2ai team to identify best practice physical health preventive care screenings to be adopted by BH providers across and PC practices.										
Task 3. Develop a training plan for PC and BH practices to support adoption of best practice screenings where there are current gaps in identified PCPs and BH providers. Training plan includes educating practices on the billing codes for PHQ-9 and SBIRT screens (many practices are unaware of ability to bill for these										

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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
screens, and absence of billing is a barrier).										
Task 4. MCC clinical integration teams provides training to PCPs and BH providers PPSs.										
Task 5. Ensure PHQ-9, SBIRT, or other behavioral health screenings are documented in participating provider EMRs.										
Task 6. Clinical integration training teams (with CPWNY counterparts for joint PPS membership) incorporate reviews of screening protocols and implementation with quarterly technical assistance meetings with providers.										
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. Ongoing communication and collaboration with MCC management and 2.a.i. project team manager who are working to establish PCMH/MU project implementation plan including EHR requirement.										
Task 2. Information will be shared monthly at BH and PCP stakeholder meetings.										
Task 3. Project manager or designee will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve where necessary.										
Task 4. Collaborate with 2.a.i. clinical integration team and IT Data Committee to discuss any issues and to brainstorm and problem-solve any shared data issues.										
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										

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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
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 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.										

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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 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.	602	602	602	602	602	602	602	602	602	602
Task Behavioral health services are co-located within PCMH/APC practices and are available.	165	165	165	165	165	165	165	165	165	165
Task 1. Establish a master list of primary care (PC) sites interested in the project (602 sites are listed in the application).										
Task 2. Establish a master list of behavioral health (BH) providers interested in the project (165 providers are listed in the application).										
Task 3. Identify with Community Partners of WNY (CPWNY, led by Catholic Medical Partners) which PC and BH care providers are in both PPSs.										
Task 4. Have PC and BH care site partners sign agreements or letters of intent indicating commitment to program.										
Task 5. Survey (such as a Survey Monkey or similar tool) sent to participating PC and BH sites asking PCMH status, NCQA level, percent of Medicaid patients served, EHR status and vendor, CCD capacity to send and receive records, use of RHIO, capacity, usage of screening instruments, etc. This survey will be coordinated with the current state assessment performed under project 2.a.i. (IDS).										
Task 6. Collaborate with CPWNY where there is overlap with PC										

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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/or BH Sites.										
Task 7. Leverage Clinical Integration Needs Assessment of participating partners to assess current experience with satellite clinic integration and willingness to consider, EHR status, RHIO relationship, capacity to send/receive records, use of screenings, etc.										
Task 8. MCC and CPWNY staff jointly determine if the restrictions on integrating Article 31 clinics into Article 28 OP PC sites are DOH or Federal regulations. Seek regulatory waiver; if waiver not feasible, asses feasibility of Article 28 clinics of hiring own BH staff.										
Task 9. Organize and convene the first of several monthly workgroup meetings of Behavioral Health and Primary Care Programs of WNY counties (meeting and phone-in option), led by teams of physician, BH leader, MCC, and CPWNY representatives.										
Task 10. Continue to meet with key stakeholders at regular intervals (bi-monthly) for those identified as ready to implement integrated model based on survey and meeting information.										
Task 11. Perform hot spotting analysis of current practices delivered in the eight WNY counties and gaps in services for the region and evaluate the gaps.										
Task 12. Coordinate messaging and communication strategy with MCC Communications Director and CPWNY to engage PC sites unsure of participation.										
Task 13. Evaluate budget of project to support gaps in service.										
Task 14. Ongoing communication and collaboration with MCC management and 2ai project director, who are working to establish PCMH/MU project implementation plan based on PC practice readiness, certification status, and related activities as referenced in 2.a.i. Requirement #7.										
Task 15. In collaboration with MCC Management and 2ai project director, analyze current status of EMR systems as outlined in 2.a.i. Requirement #7.										
Milestone #2 Develop collaborative evidence-based standards of care										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
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. Investigate various collaborative care models, review SAMHSA best practices, and arrange phone meetings with experts at University of Washington AIMS Center.										
Task 2. Work with MCC Clinical Director, Chief Medical Officer (CMO) and Clinical Quality Committee with sign-off by the Physician Steering Committee (PSC) to devise protocols utilizing chosen evidence-based standards in regards to care management protocols such as warm hand-offs.										
Task 3. Coordinate care management protocols with CPWNY, where applicable to ensure that services across the eight WNY counties are provided under one set of evidence-based standards.										
Task 4. Begin to convene monthly provider stakeholder meetings with BH and PC partners; share ideas and provide feedback back to CMO.										
Task 5. Draft final plan with MCC Clinical Director, CMO, and CPWNY partners where applicable and share with key stakeholders for feedback.										
Task 6. Finalize implementation plan with partners.										
Task 7. Project manager will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve (where necessary) the established evidence-based protocols that support integrated treatment and practice.										
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.										

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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 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.	602	602	602	602	602	602	602	602	602	602
Task 1. PC and BH practices jointly surveyed by MCC and CPWNY, where applicable to assess which preventive screenings are currently being implemented routinely for patients in both PC and BH practices.										
Task 2. MCC 2ai team to identify best practice physical health preventive care screenings to be adopted by PCPs and BH practices.										
Task 3. Develop a training plan for PC and BH practices to support adoption of best practice screenings where there are current gaps in identified PCPs and BH providers. Training plan includes educating practices on the billing codes for PHQ-9 and SBIRT screens (many practices are unaware of ability to bill for these screens, and absence of billing is a barrier).										
Task 4. MCC clinical integration teams provides training to PCPs and BH providers.										
Task 5. Ensure PHQ9, SBIRT, or other behavioral health screenings are documented in participating provider EMRs.										
Task 6. Clinical integration training teams (with CPWNY counterparts for joint PPS membership) incorporate reviews of screening protocols and implementation with quarterly technical assistance meetings with providers.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task 1. Ongoing communication and collaboration with MCC management and 2.a.i. project team who are working to establish PCMH/MU project implementation plan including EHR requirement.										
Task 2. Information will be shared monthly at BH and PCP stakeholder meetings.										
Task 3. Project manager or designee will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve where necessary.										
Task 4. Collaborate with 2.a.i. clinical integration team and IT Data Committee to discuss any issues and to brainstorm and problem-solve any shared data issues.										
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.	602	602	602	602	602	602	602	602	602	602
Task Primary care services are co-located within behavioral Health practices and are available.	602	602	602	602	602	602	602	602	602	602
Task Primary care services are co-located within behavioral Health practices and are available.	165	165	165	165	165	165	165	165	165	165
Task 1. Establish a master list of PC sites interested in the project (602 sites are listed in the application).										
Task 2. Establish a master list of BH providers interested in the project (165 providers are listed in the application).										
Task 3. Identify with CPWNY which PC and BH care providers are in both PPSs.										
Task 4. Have PC and BH care site partners sign agreements or letters of intent indicating commitment to program.										
Task 5. Survey (such as a Survey Monkey or similar tool) sent to										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
participating PC and BH sites asking PCMH status, NCQA level, percent of Medicaid patients served, EHR status and vendor, CCD capacity to send and receive records, use of RHIO, capacity, usage of screening instruments, etc. This survey will be coordinated with the current state assessment performed under project 2.a.i. (IDS).										
Task 6. Collaborate with CPWNY where there is overlap with PC and/or BH sites.										
Task 7. Leverage Clinical Integration Needs Assessment of participating partners to assess current experience with satellite clinic integration and willingness to consider, EHR status, RHIO relationship, capacity to send/receive records, use of screenings, etc.										
Task 8. Participating providers will assess and report to MCC on their status in regards to site readiness, regulatory issues (if applicable), and billing issues.										
Task 9. Ensure primary care providers are culturally sensitive and aware of issues that may make clients reluctant to seek healthcare outside of the behavioral health setting. Link providers to cultural competency/health literacy trainings coordinated by the PPS.										
Task 10. Organize and convene the first of several monthly work group of Behavioral Health and Primary Care Programs of WNY counties (meeting and phone-in option). Led by teams of physicians, BH leaders, MCC, and CPWNY representatives.										
Task 11. Continue to meet with key stakeholders at regular intervals (bi-monthly) for those identified as ready to implement integrated model based on survey and meeting information.										
Task 12. Perform hot spotting analysis of current practices delivered in the eight WNY counties and gaps in services for the region and evaluate the gaps.										
Task 13. Coordinate messaging and communication strategy with MCC Communications Director and CPWNY to engage PC sites unsure of participation.										
Task 14. Evaluate budget of project to support gaps in service.										

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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 15. Ongoing communication and collaboration with MCC management and 2.a.i. project director, who are working to establish PCMH/MU project implementation plan based on PC practice readiness, certification status, and related activities as referenced in 2.a.i. Requirement #7.										
Task 16. In collaboration with MCC Management and 2a.i. project director, analyze current status of EMR systems as outlined in 2.a.i. Requirement #7.										
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. Investigate various evidence-based models, review SAMHSA best practices, and arrange phone meetings with experts and vendors for telepsychiatry services.										
Task 2. Work with MCC Clinical Director, Chief Medical Officer (CMO) and Clinical Quality Committee with sign-off by the Physician Steering Committee (PSC) to devise protocols utilizing chosen evidence-based standards in regards to care management protocols such as warm hand-offs.										
Task 3. Coordinate care management protocols with CPWNY, where applicable to ensure that services across the eight WNY counties are provided under one set of evidence-based standards.										
Task 4. PC partners; share ideas and provide feedback back to CMO.										
Task 5. Draft final plan with MCC Clinical Director, CMO, and CPWNY partners where applicable and share with key stakeholders for feedback.										
Task 6. Finalize implementation plan with partners.										
Task 7. Project manager will meet with each integrated site staff 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
leadership at least quarterly to mutually assess and problem-solve (where necessary) the established evidence-based protocols that support integrated treatment and practice.										
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.	602	602	602	602	602	602	602	602	602	602
Task 1. PC and BH practices jointly surveyed by MCC and CPWNY, where applicable to assess which preventive screenings are currently being implemented routinely for patients in both PC and BH practices.										
Task 2. MCC 2ai team to identify best practice physical health preventive care screenings to be adopted by BH providers across and PC practices.										
Task 3. Develop a training plan for PC and BH practices to support adoption of best practice screenings where there are current gaps in identified PCPs and BH providers. Training plan includes educating practices on the billing codes for PHQ-9 and SBIRT screens (many practices are unaware of ability to bill for these screens, and absence of billing is a barrier).										
Task 4. MCC clinical integration teams provides training to PCPs and BH providers PPSs.										
Task 5. Ensure PHQ-9, SBIRT, or other behavioral health screenings are documented in participating provider EMRs.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 6. Clinical integration training teams (with CPWNY counterparts for joint PPS membership) incorporate reviews of screening protocols and implementation with quarterly technical assistance meetings with providers.										
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. Ongoing communication and collaboration with MCC management and 2.a.i. project team manager who are working to establish PCMH/MU project implementation plan including EHR requirement.										
Task 2. Information will be shared monthly at BH and PCP stakeholder meetings.										
Task 3. Project manager or designee will meet with each integrated site staff and leadership at least quarterly to mutually assess and problem-solve where necessary.										
Task 4. Collaborate with 2.a.i. clinical integration team and IT Data Committee to discuss any issues and to brainstorm and problem-solve any shared data issues.										
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										

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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
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 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.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
in this project.	

Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 3.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.

Resistance to change or failure to adopt consistent clinical guidelines will negatively impact DSRIP shared outcome metrics. A clinical readiness needs assessment for each participating provider will be completed. Joint efforts to ensure inclusivity, transparency, evidence-based justification, and other consensus-building techniques to maximize practitioner buy-in and ownership. Provider performance and compliance with standards will be monitored by the Physician Performance Sub-Committee (as described in project 2.a.i.), and the PPS will work with providers with low performance scores to address the gaps.

Crisis intervention resources are inconsistent and poorly understood across WNY. Additionally, first responders typically respond to behavioral health calls by transporting individuals to the ED, often resulting in an unnecessary ED visit and/or admission. MCC will lead a cross-organizational work group to assess and evaluate efforts aimed at consistent goals and outcomes. Collaborative efforts and leveraging of services towards modeling a crisis intervention team approach will assist law enforcement and providers to direct the care needed. Consideration for outreach capabilities to consult with psychiatrists/medical provider prior to taking action and sending a patient to the hospital.

Lack of established central triage system/model that will serve all eight WNY counties. One mitigation strategy would be to identify one provider as the central triage service for this model. Another possibility is for all crisis centers for designated counties to collaboratively develop a central triage tool that will be implemented to provide consistent response to crisis stabilization. Once developed, all behavioral health providers in the respective counties will be trained on the behavioral health triage system to utilize crisis/emergency services effectively. Create triage tool for project use.

The lack of respite services and emergency housing in WNY could impede the effectiveness of the crisis stabilization project. Utilization of these services are a key component to advoiding unnecessary and costly hospital services. Partner with existing housing and care agencies to expand services to help establish options.

Crisis stabilization services require a high level of service and are not consistently reimbursed by Medicaid managed care organizations. Collaborate with payers on payment structures, reporting practices, and metrics. Evaluate billing options based on regulations. Assist in translation to providers to assure clarity in procedures.

There is a shortage of behavioral health specialists and services in WNY. Work with area colleges and universities to determine how many students are in the pipeline, review curriculum options, discuss expanding clinical training opportunities, and encourage behavioral health-related internships. Assist in placement students/interns/fellows enhancing the pool of available and qualified personnel. With an expanded pool of providers much needed services can also be expanded.

Due to compatibility and regulatory issues, EHR systems may be difficult to use. Map existing EHR options and points in the crisis stabilization

model where information sharing fails. Evaluate options to help eliminate the gasp and/or develop compliant options for proper hand-off of information. Establish consistent mechanism for communication and guidance tools.

It will be important to provide a relatively uniform/transparent experience for patients regardless of where they seek care. MCC will work with Finger Lake PPS and Community Partners of WNY (led by Catholic Medical Partners) to share registry information, use standardized referral protocols, utilize uniform tracking and reporting systems, adopt universal alert messaging via the RHIO, and maintain common messaging to educate patients about crisis stabilization servi

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	12,750

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
3,103	4,501	58.84%	3,149	35.30%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (7,650)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ethelen	Baseline or Performance Documentation	48_PMDL3815_1_3_20160203082842_3aii_PE_registry_DY1Q3.xlsx	Patient engagement registry showing 948 patients in Q3	02/03/2016 08:29 AM

Narrative Text :

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

patients previously reported in DY1Q2: 3,103. new patients engaged in DY1Q3: 948. total cumulative patients engaged: 4,501

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	Project	N/A	In Progress	07/01/2015	03/01/2016	07/01/2015	03/01/2016	03/31/2016	DY1 Q4
Task PPS has established a crisis intervention program that includes outreach, mobile crisis, and intensive crisis services.	Project		In Progress	07/01/2015	03/01/2016	07/01/2015	03/01/2016	03/31/2016	DY1 Q4
Task 1. Convene Crisis Stabilization and Crisis Center Workgroup to plan out review of project (first meeting scheduled for 08/19/2015).	Project		In Progress	08/19/2015	03/01/2016	08/19/2015	03/01/2016	03/31/2016	DY1 Q4
Task 2. Establish Crisis Stabilization Advisory Group membership list.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task 3. Host the first quarterly advisory meeting (person/phone call in).	Project		Completed	08/19/2015	08/19/2015	08/19/2015	08/19/2015	09/30/2015	DY1 Q2
Task 4. Develop monthly learning exchange meetings/calls with all crisis program providers.	Project		Completed	09/01/2015	12/01/2015	09/01/2015	12/01/2015	12/31/2015	DY1 Q3
Task 5. Create map of current services delivered by program by county.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Evaluate gaps in services.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. Evaluate budget of project to support gaps in service.	Project		In Progress	07/01/2015	03/01/2016	07/01/2015	03/01/2016	03/31/2016	DY1 Q4
Task 8. Map out capacity-building plan of existing programs and implementation plan of new services.	Project		In Progress	07/01/2015	03/01/2016	07/01/2015	03/01/2016	03/31/2016	DY1 Q4
Task 9. Research and review EBP and established models that share dynamics specific to rural area challenges.	Project		In Progress	08/01/2015	12/31/2015	08/01/2015	03/01/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 10. Develop expanded crisis intervention model based on strengths identified in current model.	Project		In Progress	08/01/2015	03/01/2016	08/01/2015	03/01/2016	03/31/2016	DY1 Q4
Task 11. Utilize Crisis Services as lead facilitators to train partners identified to expand outreach mobile crisis and/or intensive crisis services.	Project		Not Started	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task 12. Provide ongoing training and support to partners as needed.	Project		Not Started	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 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	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS has implemented diversion management protocol with PPS Hospitals (specifically Emergency Departments).	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1. Evaluate gaps in services.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Map out capacity-building plan of existing programs and implementation plan of new services.	Project		In Progress	07/01/2015	03/01/2016	07/01/2015	03/01/2016	03/31/2016	DY1 Q4
Task 3. Develop crisis stabilization algorithm protocol for hospital diversion for Crisis Centers, Mobile Services, Health Homes, law enforcement, other providers.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Convene Health Home leaders to review algorithm and solidify linkages.	Project		Not Started	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task 5. Review algorithm with following stakeholder groups: Crisis Stabilization Advisory Committee, Crisis Center Provider committee, Crisis Center Police Mental Health Coordination Project for community feedback.	Project		Not Started	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task 6. Utilize feedback and begin to test protocols at two identified sites.	Project		Not Started	02/01/2016	03/31/2016	02/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide	Project	N/A	Not Started	01/01/2016	03/31/2016	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 1. MCC leadership to arrange meetings with payers to evaluate current requirements and reimbursement rates for existing services.	Project		Not Started	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task 2. MCC leadership establishes agreed upon rates for existing and for any new services defined.	Project		Not Started	01/01/2016	03/01/2016	01/01/2016	03/01/2016	03/31/2016	DY1 Q4
Task 3. Partners informed of rates and agreements and MCC signs agreements.	Project		Not Started	03/01/2016	03/31/2016	03/01/2016	03/31/2016	03/31/2016	DY1 Q4
Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop consensus on treatment protocols.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated treatment care protocols are in place.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Coordinate with project 2.b.iii. (ED Care Triage) to establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Project		Not Started	01/31/2016	03/31/2017	01/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Meet with 2biii Project Manager to review protocols developed for ED Triage and discuss implementation strategies, lessons learned, etc. as it relates to 3aii project.	Project		Not Started	01/31/2016	03/31/2017	01/31/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Begin to implement protocols leveraged from the ED Triage 2biii project	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 4. Monitor changes on a quarterly basis and/or as needed.	Project		In Progress	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Include at least one hospital with specialty psychiatric services	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
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	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	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 Hospital	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. ECMCC CPEP is our designated hospital with specialty psychiatric services and crisis-oriented psychiatric services.	Project		Completed	07/01/2015	07/15/2015	07/01/2015	07/15/2015	09/30/2015	DY1 Q2
Task 2. Hot spot analysis and provider surveys will be completed, sent out, and reviewed by MCC leadership	Project		In Progress	08/01/2015	03/31/2016	08/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Expansion of services to be determined as a goal by MCC leadership and ECMCC leadership as a result of reviewing data gathered from CNA, hotspot analysis and provider surveys.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task PPS includes hospitals with observation unit or off campus crisis residence locations for crisis monitoring.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 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 Hospital	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 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 Clinic	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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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 Mental Health	In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 1. Key stakeholder provider group is developed and convened to discuss and identify existing gaps in services and barriers to access.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Key stakeholder group identifies community strengths and devises a collaborative plan to address barriers and how observation beds and crisis residence beds will be coordinated.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Locations identified to expand services identified by key stakeholders (City Mission, HOME – in Niagara, Chautauqua and Cattaraugus Counties).	Project		Completed	07/02/2015	09/30/2015	07/02/2015	09/30/2015	09/30/2015	DY1 Q2
Task 4. Agreements to be negotiated among MCC leadership and identified providers in regards to expansion of services.	Project		In Progress	07/16/2015	03/31/2016	07/16/2015	03/31/2016	03/31/2016	DY1 Q4
Task 5. Crisis residential beds and chemical dependency services to be established at Buffalo City Mission in partnership with ECMCC CPEP and Crisis Services Mobile Outreach Services.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. HOME to establish Rose House Model Peer Respite Services in Erie County.	Project		Completed	09/15/2015	12/31/2015	09/15/2015	12/31/2015	12/31/2015	DY1 Q3
Task 7. HOME to establish Rose House Model Peer Respite Services in Randolph, NY to serve Chautauqua/Cattaraugus Counties.	Project		In Progress	09/01/2015	03/31/2016	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8. Niagara County to establish a Rose House Plus type service of crisis respite services.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9. Evaluation protocols developed by key stakeholder team and MCC leadership.	Project		In Progress	09/01/2015	12/31/2015	09/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 10. Evaluate protocols reviewed and data collected quarterly and/or as required.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4

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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	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task PPS includes mobile crisis teams to help meet crisis stabilization needs of the community.	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Coordinated evidence-based care protocols for mobile crisis teams are in place.	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task 1. Identify existing mobile teams in Erie, Niagara, and Chautauqua counties.	Project		Completed	07/01/2015	07/15/2015	07/01/2015	07/15/2015	09/30/2015	DY1 Q2
Task 2. Review criteria for protocol (NYS Mental Hygiene Law-9.45).	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Assess mobile team services in Cattaraugus, Allegany, Wyoming, Genesee, and Orleans counties to determine gaps in service to meet this requirement.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Identify implementation of new mobile services based on review of need, data evaluation, and budget.	Project		In Progress	08/19/2015	12/31/2016	08/19/2015	12/31/2016	12/31/2016	DY2 Q3
Task 5. Utilize Crisis Services to develop training on new protocols, EBP, and existing resources.	Project		Not Started	10/15/2015	12/31/2015	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Crisis Services staff will implement and train new partners on identified protocols and resources	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
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	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Provider	Safety Net Practitioner -	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.		Primary Care Provider (PCP)							
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Hospital	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 1. Work with MCC leadership team and 2ai project to lay out plan by end of DY3.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task 2. In collaboration with MCC Management and 2ai project director, analyze current status of EMR systems as outlined in 2ai requirement 7.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	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	08/19/2015	05/01/2016	08/19/2015	05/01/2016	06/30/2016	DY2 Q1
Task PPS has implemented central triage service among psychiatrists and behavioral health providers.	Project		In Progress	08/19/2015	05/01/2016	08/19/2015	05/01/2016	06/30/2016	DY2 Q1
Task 1. Collect triage tool examples for Crisis Center provider group to review.	Project		In Progress	08/19/2015	01/15/2016	08/19/2015	01/15/2016	03/31/2016	DY1 Q4
Task 2. Evaluate and assess current tools, policies, and resources and commit to consistent model for all providers to use.	Project		In Progress	08/19/2015	03/31/2016	08/19/2015	03/31/2016	03/31/2016	DY1 Q4
Task 3. Coordinate training on model for all Crisis Center providers; consider targeting specific protocols for targeted participants such as Schools, Shelters, law enforcement, etc.	Project		In Progress	08/19/2015	04/15/2016	08/19/2015	04/15/2016	06/30/2016	DY2 Q1
Task	Project		Not Started	01/01/2016	05/01/2016	01/01/2016	05/01/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
4. Implement universal triage tool for Crisis Stabilization providers.									
Task 5. Coordinate and help secure partner agreements with providers as outlined in 2ai Requirement 8.	Project		In Progress	09/01/2015	05/01/2016	09/01/2015	05/01/2016	06/30/2016	DY2 Q1
Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. MCC leadership will identify and recruit members of a Clinical/Quality development committee.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Identified leaders will meet as necessary to discuss and develop metrics, action plans, etc.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
3. Work with MCC leadership team on integration of this requirement with Clinical/Quality Committee development as outlined in 2ai requirement 7.									
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	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	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Confirm that providers participating in this project are using EHRs and other technical platforms to track patients. (Coordinate with project 2ai and other PPS-wide integration efforts.)	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 2. Ongoing communication and collaboration with MCC management and 2ai project manager who are working to establish EHR requirement	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. In collaboration with MCC Management and 2ai project director, analyze current status of EMR systems as outlined in 2ai requirement 7.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement 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. Convene Crisis Stabilization and Crisis Center Workgroup to plan out review of project (first meeting scheduled for 08/19/2015).										
Task 2. Establish Crisis Stabilization Advisory Group membership list.										
Task 3. Host the first quarterly advisory meeting (person/phone call in).										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 4. Develop monthly learning exchange meetings/calls with all crisis program providers.										
Task 5. Create map of current services delivered by program by county.										
Task 6. Evaluate gaps in services.										
Task 7. Evaluate budget of project to support gaps in service.										
Task 8. Map out capacity-building plan of existing programs and implementation plan of new services.										
Task 9. Research and review EBP and established models that share dynamics specific to rural area challenges.										
Task 10. Develop expanded crisis intervention model based on strengths identified in current model.										
Task 11. Utilize Crisis Services as lead facilitators to train partners identified to expand outreach mobile crisis and/or intensive crisis services.										
Task 12. Provide ongoing training and support to partners as needed.										
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. Evaluate gaps in services.										
Task 2. Map out capacity-building plan of existing programs and implementation plan of new services.										
Task 3. Develop crisis stabilization algorithm protocol for hospital diversion for Crisis Centers, Mobile Services, Health Homes, law enforcement, other providers.										
Task 4. Convene Health Home leaders to review algorithm and solidify linkages.										

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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. Review algorithm with following stakeholder groups: Crisis Stabilization Advisory Committee, Crisis Center Provider committee, Crisis Center Police Mental Health Coordination Project for community feedback.										
Task 6. Utilize feedback and begin to test protocols at two identified sites.										
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. MCC leadership to arrange meetings with payers to evaluate current requirements and reimbursement rates for existing services.										
Task 2. MCC leadership establishes agreed upon rates for existing and for any new services defined.										
Task 3. Partners informed of rates and agreements and MCC signs agreements.										
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. Coordinate with project 2.b.iii. (ED Care Triage) to establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.										
Task 2. Meet with 2biii Project Manager to review protocols developed for ED Triage and discuss implementation strategies, lessons learned, etc. as it relates to 3aii project.										
Task 3. Begin to implement protocols leveraged from the ED Triage										

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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
2biii project										
Task 4. Monitor changes on a quarterly basis and/or as needed.										
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	2	3	4	5	6	7	8	9	10
Task 1. ECMCC CPEP is our designated hospital with specialty psychiatric services and crisis-oriented psychiatric services.										
Task 2. Hot spot analysis and provider surveys will be completed, sent out, and reviewed by MCC leadership										
Task 3. Expansion of services to be determined as a goal by MCC leadership and ECMCC leadership as a result of reviewing data gathered from CNA, hotspot analysis and provider surveys.										
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.	0	2	3	4	5	6	7	8	9	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.	0	2	4	8	12	18	25	32	36	40

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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	10	20	30	40	50	60	70
Task 1. Key stakeholder provider group is developed and convened to discuss and identify existing gaps in services and barriers to access.										
Task 2. Key stakeholder group identifies community strengths and devises a collaborative plan to address barriers and how observation beds and crisis residence beds will be coordinated.										
Task 3. Locations identified to expand services identified by key stakeholders (City Mission, HOME – in Niagara, Chautauqua and Cattaraugus Counties).										
Task 4. Agreements to be negotiated among MCC leadership and identified providers in regards to expansion of services.										
Task 5. Crisis residential beds and chemical dependency services to be established at Buffalo City Mission in partnership with ECMCC CPEP and Crisis Services Mobile Outreach Services.										
Task 6. HOME to establish Rose House Model Peer Respite Services in Erie County.										
Task 7. HOME to establish Rose House Model Peer Respite Services in Randolph, NY to serve Chautauqua/Cattaraugus Counties.										
Task 8. Niagara County to establish a Rose House Plus type service of crisis respite services.										
Task 9. Evaluation protocols developed by key stakeholder team and MCC leadership.										
Task 10. Evaluate protocols reviewed and data collected quarterly and/or as required.										
Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.										
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
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 1. Identify existing mobile teams in Erie, Niagara, and Chautauqua counties.										
Task 2. Review criteria for protocol (NYS Mental Hygiene Law-9.45).										
Task 3. Assess mobile team services in Cattaraugus, Allegany, Wyoming, Genesee, and Orleans counties to determine gaps in service to meet this requirement.										
Task 4. Identify implementation of new mobile services based on review of need, data evaluation, and budget.										
Task 5. Utilize Crisis Services to develop training on new protocols, EBP, and existing resources.										
Task 6. Crisis Services staff will implement and train new partners on identified protocols and resources										
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	2	6	10	20	30	40	50	60	80
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	10	20	30	40	50	60
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	2	3	3	4	5	6	7	8	9
Task EHR meets connectivity to RHIO's HIE and SHIN-NY	0	0	0	10	20	30	40	50	60	70

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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 Alerts and secure messaging functionality are used to facilitate crisis intervention services.										
Task 1. Work with MCC leadership team and 2ai project to lay out plan by end of DY3.										
Task 2. In collaboration with MCC Management and 2ai project director, analyze current status of EMR systems as outlined in 2ai requirement 7.										
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. Collect triage tool examples for Crisis Center provider group to review.										
Task 2. Evaluate and assess current tools, policies, and resources and commit to consistent model for all providers to use.										
Task 3. Coordinate training on model for all Crisis Center providers; consider targeting specific protocols for targeted participants such as Schools, Shelters, law enforcement, etc.										
Task 4. Implement universal triage tool for Crisis Stabilization providers.										
Task 5. Coordinate and help secure partner agreements with providers as outlined in 2ai Requirement 8.										
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										

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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 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. MCC leadership will identify and recruit members of a Clinical/Quality development committee.										
Task 2. Identified leaders will meet as necessary to discuss and develop metrics, action plans, etc.										
Task 3. Work with MCC leadership team on integration of this requirement with Clinical/Quality Committee development as outlined in 2ai requirement 7.										
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. Confirm that providers participating in this project are using EHRs and other technical platforms to track patients. (Coordinate with project 2ai and other PPS-wide integration efforts.)										
Task 2. Ongoing communication and collaboration with MCC management and 2ai project manager who are working to establish EHR requirement										
Task 3. In collaboration with MCC Management and 2ai project director, analyze current status of EMR systems as outlined in										

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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
2ai requirement 7.										

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. Convene Crisis Stabilization and Crisis Center Workgroup to plan out review of project (first meeting scheduled for 08/19/2015).										
Task 2. Establish Crisis Stabilization Advisory Group membership list.										
Task 3. Host the first quarterly advisory meeting (person/phone call in).										
Task 4. Develop monthly learning exchange meetings/calls with all crisis program providers.										
Task 5. Create map of current services delivered by program by county.										
Task 6. Evaluate gaps in services.										
Task 7. Evaluate budget of project to support gaps in service.										
Task 8. Map out capacity-building plan of existing programs and implementation plan of new services.										
Task 9. Research and review EBP and established models that share dynamics specific to rural area challenges.										
Task 10. Develop expanded crisis intervention model based on strengths identified in current model.										
Task 11. Utilize Crisis Services as lead facilitators to train partners identified to expand outreach mobile crisis and/or intensive crisis services.										
Task 12. Provide ongoing training and support to partners as needed.										

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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 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. Evaluate gaps in services.										
Task 2. Map out capacity-building plan of existing programs and implementation plan of new services.										
Task 3. Develop crisis stabilization algorithm protocol for hospital diversion for Crisis Centers, Mobile Services, Health Homes, law enforcement, other providers.										
Task 4. Convene Health Home leaders to review algorithm and solidify linkages.										
Task 5. Review algorithm with following stakeholder groups: Crisis Stabilization Advisory Committee, Crisis Center Provider committee, Crisis Center Police Mental Health Coordination Project for community feedback.										
Task 6. Utilize feedback and begin to test protocols at two identified sites.										
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. MCC leadership to arrange meetings with payers to evaluate current requirements and reimbursement rates for existing services.										
Task 2. MCC leadership establishes agreed upon rates for existing and for any new services defined.										
Task 3. Partners informed of rates and agreements and MCC signs agreements.										

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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 #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. Coordinate with project 2.b.iii. (ED Care Triage) to establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.										
Task 2. Meet with 2biii Project Manager to review protocols developed for ED Triage and discuss implementation strategies, lessons learned, etc. as it relates to 3aii project.										
Task 3. Begin to implement protocols leveraged from the ED Triage 2biii project										
Task 4. Monitor changes on a quarterly basis and/or as needed.										
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.	11	11	11	11	11	11	11	11	11	11
Task 1. ECMCC CPEP is our designated hospital with specialty psychiatric services and crisis-oriented psychiatric services.										
Task 2. Hot spot analysis and provider surveys will be completed, sent out, and reviewed by MCC leadership										
Task 3. Expansion of services to be determined as a goal by MCC leadership and ECMCC leadership as a result of reviewing data										

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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
gathered from CNA, hotspot analysis and provider surveys.										
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.	11	11	11	11	11	11	11	11	11	11
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.	40	40	40	40	40	40	40	40	40	40
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.	80	92	92	92	92	92	92	92	92	92
Task 1. Key stakeholder provider group is developed and convened to discuss and identify existing gaps in services and barriers to access.										
Task 2. Key stakeholder group identifies community strengths and devises a collaborative plan to address barriers and how observation beds and crisis residence beds will be coordinated.										
Task 3. Locations identified to expand services identified by key stakeholders (City Mission, HOME – in Niagara, Chautauqua and Cattaraugus Counties).										
Task 4. Agreements to be negotiated among MCC leadership and identified providers in regards to expansion of services.										
Task 5. Crisis residential beds and chemical dependency services to be established at Buffalo City Mission in partnership with ECMCC CPEP and Crisis Services Mobile Outreach Services.										
Task 6. HOME to establish Rose House Model Peer Respite 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
in Erie County.										
Task 7. HOME to establish Rose House Model Peer Respite Services in Randolph, NY to serve Chautauqua/Cattaraugus Counties.										
Task 8. Niagara County to establish a Rose House Plus type service of crisis respite services.										
Task 9. Evaluation protocols developed by key stakeholder team and MCC leadership.										
Task 10. Evaluate protocols reviewed and data collected quarterly and/or as required.										
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 1. Identify existing mobile teams in Erie, Niagara, and Chautauqua counties.										
Task 2. Review criteria for protocol (NYS Mental Hygiene Law-9.45).										
Task 3. Assess mobile team services in Cattaraugus, Allegany, Wyoming, Genesee, and Orleans counties to determine gaps in service to meet this requirement.										
Task 4. Identify implementation of new mobile services based on review of need, data evaluation, and budget.										
Task 5. Utilize Crisis Services to develop training on new protocols, EBP, and existing resources.										
Task 6. Crisis Services staff will implement and train new partners on identified protocols and resources										
Milestone #8 Ensure that all PPS safety net providers have actively connected EHR systems with local health information										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
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.	100	126	126	126	126	126	126	126	126	126
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	70	81	81	81	81	81	81	81	81	81
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	10	11	11	11	11	11	11	11	11	11
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	80	92	92	92	92	92	92	92	92	92
Task Alerts and secure messaging functionality are used to facilitate crisis intervention services.										
Task 1. Work with MCC leadership team and 2ai project to lay out plan by end of DY3.										
Task 2. In collaboration with MCC Management and 2ai project director, analyze current status of EMR systems as outlined in 2ai requirement 7.										
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. Collect triage tool examples for Crisis Center provider group to review.										
Task 2. Evaluate and assess current tools, policies, and resources and commit to consistent model for all providers to use.										
Task 3. Coordinate training on model for all Crisis Center providers;										

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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
consider targeting specific protocols for targeted participants such as Schools, Shelters, law enforcement, etc.										
Task 4. Implement universal triage tool for Crisis Stabilization providers.										
Task 5. Coordinate and help secure partner agreements with providers as outlined in 2ai Requirement 8.										
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 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. MCC leadership will identify and recruit members of a Clinical/Quality development committee.										
Task 2. Identified leaders will meet as necessary to discuss and develop metrics, action plans, etc.										
Task 3. Work with MCC leadership team on integration of this requirement with Clinical/Quality Committee development as outlined in 2ai requirement 7.										

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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 #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. Confirm that providers participating in this project are using EHRs and other technical platforms to track patients. (Coordinate with project 2ai and other PPS-wide integration efforts.)										
Task 2. Ongoing communication and collaboration with MCC management and 2ai project manager who are working to establish EHR requirement										
Task 3. In collaboration with MCC Management and 2ai project director, analyze current status of EMR systems as outlined in 2ai requirement 7.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement 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	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
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.	

Milestone Review Status

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #11	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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

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

Instructions :

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

Existing and new guidelines with differing recommendations has led to confusion among practitioners. Practice transformation includes embedding and reinforcing the Million Hearts (MH) Program goals, practice guidelines and tools into each practice. We will use a combination of academic detailing, practice facilitation, collaborative learning groups, and patient engagement.

Training is a core part of the care team reorientation. A comprehensive training initiative will serve as the backbone of the CVD management project. Other educational media will vary based on the practice location and characteristics: for large urban centers, onsite training is feasible. For rural practices, collaborative learning models and content will be communicated through meetings, written documents and embedded in the medical decision support systems of the regional EHRs.

The role, responsibilities, workflow, protocols, and performance evaluation of the CVD initiative will be accessible by each office. Use of the CVD endpoints addresses Standard 3D (population health management) of 2014 PCMH requirements. Longer-term, participation will improve provider reimbursement rates via specific programs such as Meaningful Use of EHR and PCMH. Providers who attend training sessions may also be compensated for their time.

Sustained progress in cardiovascular health requires a campaign to change deeply ingrained beliefs and behaviors in providers and patients. MCC will identify areas of overlap and mutual interest among the 11 projects and foster collaboration whenever possible. New scientific developments will be communicated to providers at meetings and educational sessions on the website. Current CVD care/treatment guidelines will be instituted PPS-wide by building them into the practice transformation described above to meet level 3 PCMH.

The absence of a functional database would impede reporting and present significant obstacles to physician feedback. Participating PCMH locations will use electronic health registries to record, track, analyze, and report on clinical data. Project 2.a.i will build RHIO connectivity, enhanced communication, and care management data-sharing between primary care and cardiovascular specialists, mental health, health homes, and community support agencies. The meaningful use of this electronic clinical data will be built into the practice transformation to meet level 3 PCMH.

It may be difficult for some providers to accept and use blood pressure data generated at home. Periodic educational programs will emphasize the need for non-office blood pressure determination. In addition, home blood pressure monitoring is not reimbursable to physicians. Practice transformation will include the phase-in of home blood pressure monitoring to meet level 3 PCMH. Reimbursement changes will also be required for physicians.

Project 2.a.i is expected to support easy-to-use point-of-care decision support based on evidence-based algorithms to make actionable information

available for the practice team. Clinical integration of multiple data sources (e.g., laboratory data) will be critical to present the "ABCs" metrics for blood pressure and cholesterol control.

Close coordination with bordering Community Partners of WNY (CPWNY, led by Catholic Medical Partners) will be necessary to address CVD in the Medicaid target population. To avoid conflicting or inconsistent messages regarding cardiovascular disease and risk factor management, PPSs will use materials developed by and made available through the MH Program. Following MH protocols will further ensure that patients encounter a comparable experience regardless of where they seek care. Representatives from MCC will meet regularly with CPWNY to coordinate timing of messaging, address issues, and share lessons learned.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	32,800

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
2,288	4,302	83.75%	835	13.12%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (5,137)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ethelen	Baseline or Performance Documentation	48_PMDL4215_1_3_20160202184615_3bi_PE_registry_DY1Q2.xlsx	Patient engagement registry showing 744 patients engaged in Q2 (supplemental file to reconcile patient engagement total for the year)	02/02/2016 06:48 PM
ethelen	Baseline or Performance Documentation	48_PMDL4215_1_3_20160202183318_3bi_PE_registry_DY1Q3.xlsx	Patient engagement registry showing 2,159 patients engaged in Q3	02/02/2016 06:33 PM

Narrative Text :

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

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Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project	N/A	In Progress	08/03/2015	09/30/2017	08/03/2015	09/30/2017	09/30/2017	DY3 Q2
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	08/03/2015	09/30/2017	08/03/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. Develop comprehensive MCC partner database for MCC partners included in the management of CVD. Partner database will categorize partners by provider type (including ambulatory care or community care partner) and demonstrate changes to the network list.	Project		In Progress	08/03/2015	09/30/2016	08/03/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Collect appropriate clinical tools necessary for the different goals of the Million Hearts Program (MHP): blood pressure guidelines, cholesterol management guidelines, and the tools for smoking cessation.	Project		In Progress	08/03/2015	09/30/2016	08/03/2015	09/30/2016	09/30/2016	DY2 Q2
Task 3. Disseminate written evidence-based treatment protocols for managing CVD using the techniques and resources provided on the Million Hearts Campaign program website.	Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 4. Define priority target population, and develop a framework for patient database to include risk stratified registries and blood pressure measurements.	Project		In Progress	09/02/2015	09/30/2016	09/02/2015	09/30/2016	09/30/2016	DY2 Q2
Task 5. Identify pilot PCP sites to implement MHP.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 6. Meet with each practice site on identified list.	Project		Not Started	01/01/2016	03/31/2016	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 7. List all PCP sites that plan on using Million Hearts registries and work on process flows at each PCP site to manage CVD population using Million Hearts criteria.	Project		Not Started	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 8. Develop process and identify vendor for patient registry/database development. Vendor to interface with data points available through the regional RHIO (HEALTHeLINK) to integrate information from disparate EHRs from primary care offices.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 9. Pilot test patient database to integrate EHR data points from a variety of Primary Care offices relevant to risk stratification, blood pressure, and cardiovascular medications.	Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 10. Track and monitor patient engagement at each PCP practice site and build quarterly performance metrics related to the four program areas in Million Hearts to verify continuous improvement.	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 11. Begin reporting on implementation of project requirements quarterly according to project milestone reporting requirements.	Project		Not Started	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Project	N/A	In Progress	08/03/2015	03/31/2018	08/03/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	08/03/2015	03/31/2018	08/03/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	08/03/2015	03/31/2018	08/03/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	08/03/2015	03/31/2018	08/03/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Project		In Progress	08/03/2015	03/31/2018	08/03/2015	03/31/2018	03/31/2018	DY3 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS uses alerts and secure messaging functionality.									
Task 1. Conduct gap analysis to determine which providers have already completed PCMH/MU or other connectivity readiness assessment. Include the following questions: Is the practice/providers/patients currently connected to the HIE? If not, is an agreement in place? If so, what is the scope of the connectivity (% of providers; % of patients)? Does EHR meet connectivity requirements of RHIO/SHIN-NY? Name of EHR, version, and electronic functionalities in use	Project		In Progress	08/03/2015	06/30/2016	08/03/2015	06/30/2016	06/30/2016	DY2 Q1
Task 2. Develop strategy for low-cost data connectivity between ISPs (e.g., WNY R-AHEC) and local practice plans to determine minimum hardware and software requirements.	Project		In Progress	09/07/2015	06/30/2016	09/07/2015	06/30/2016	06/30/2016	DY2 Q1
Task 3. Gather results from readiness assessments already conducted.	Project		In Progress	09/07/2015	06/30/2016	09/07/2015	06/30/2016	06/30/2016	DY2 Q1
Task 4. Issue request for applications (RFA) or other action step for readiness assessment and transformation support services.	Project		In Progress	10/05/2015	06/30/2016	10/05/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Select vendor or implement other structure for readiness assessment and transformation support services.	Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 6. Identify funding model and/or PPS provider incentive model for EHR with the Finance Committee.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Connect PPS providers to MCC enterprise DSRIP solution.	Project		Not Started	10/03/2016	06/30/2017	10/03/2016	06/30/2017	06/30/2017	DY3 Q1
Task 8. Implement enterprise DSRIP solution and start data exchange.	Project		Not Started	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task 9. Implement PPS providers in waves grouped by the partner's ability to connect and integrate into the solution; start with the most able to connect; add others as they establish their capabilities.	Project		Not Started	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task 10. Systematically contact PPS providers to provide the	Project		Not Started	01/02/2017	06/30/2017	01/02/2017	06/30/2017	06/30/2017	DY3 Q1

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recommended enterprise DSRIP solution.									
Task 11. Facilitate QE participation agreements with MCC providers.	Project		Not Started	04/04/2017	09/30/2017	04/04/2017	09/30/2017	09/30/2017	DY3 Q2
Task 12. Implement and deploy patient record look-up training.	Project		Not Started	09/04/2017	12/31/2017	09/04/2017	12/31/2017	12/31/2017	DY3 Q3
Task 13. Implement and deploy MCC DSRIP dashboard reporting capabilities. Provide EHR vendor documentation, screenshots, and/or samples of transactions to public health registries. Designate experts at each PCP site for ongoing support.	Project		Not Started	09/04/2017	12/31/2017	09/04/2017	12/31/2017	12/31/2017	DY3 Q3
Task 14. Implement and deploy alerts. Provide EHR vendor documentation, screenshots, and/or evidence of use of alerts.	Project		Not Started	10/02/2017	12/31/2017	10/02/2017	12/31/2017	12/31/2017	DY3 Q3
Task 15. Implement and deploy secure Direct messaging. Provide EHR vendor documentation, screenshots, and/or evidence of use of secure Direct messaging.	Project		Not Started	10/02/2017	12/31/2017	10/02/2017	12/31/2017	12/31/2017	DY3 Q3
Task 16. Continuously add MCC providers when their EHR and data exchange capabilities reach the minimal level required to connect to the MCC EHR and data exchange/HIE.	Project		Not Started	10/02/2017	12/31/2017	10/02/2017	12/31/2017	12/31/2017	DY3 Q3
Task 17. Maintain list of all PPS safety net providers with secure Direct messaging capabilities who completed training. Report to Physician Performance Sub-Committee.	Project		Not Started	01/01/2018	03/31/2018	01/01/2018	03/31/2018	03/31/2018	DY3 Q4
Task 18. MCC providers who are not actively exchanging systems will be reviewed by the Physician Performance Sub-Committee. Corrective actions will be implemented for those members found noncompliant.	Project		Not Started	07/11/2016	03/29/2018	07/11/2016	03/29/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Project	N/A	In Progress	08/03/2015	03/31/2018	08/03/2015	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	08/03/2015	03/31/2018	08/03/2015	03/31/2018	03/31/2018	DY3 Q4
Task	Provider	Practitioner - Primary	In Progress	08/03/2015	03/31/2018	08/03/2015	03/31/2018	03/31/2018	DY3 Q4

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PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.		Care Provider (PCP)							
Task 1. Conduct Safety Net MU stage 2 CMS/PCMH level 3 readiness assessment: (a) identify site-specific IT/care management leadership, (b) determine current EHR PCMH/MU certification status, and (c) identify site-specific barriers and risks to implementing a MU/PCMH Level 3 certified EHR system.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task 2. Facilitate engagement with MU/PCMH-certified EHR vendors as needed.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Establish PCMH/MU project implementation plan based on primary care practice readiness and certification status.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Review PCMH implementation plan for approval by the Clinical/Quality Committee.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Ensure practices have support through the PCMH implementation process either through a vendor or through MCC PCMH coordinators.	Project		Not Started	01/02/2017	06/30/2017	01/02/2017	06/30/2017	06/30/2017	DY3 Q1
Task 6. Establish a monthly review and measurement process of implementation progress and report to Clinical/Quality Committee.	Project		Not Started	01/02/2017	09/30/2017	01/02/2017	09/30/2017	09/30/2017	DY3 Q2
Task 7. Modify implementation plan as needed based on monthly review process.	Project		Not Started	02/02/2017	09/30/2017	02/02/2017	09/30/2017	09/30/2017	DY3 Q2
Task 8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.	Project		Not Started	01/03/2017	03/31/2018	01/03/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	08/03/2015	03/31/2017	08/03/2015	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	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Define IT requirements for	Project		Not Started	03/31/2016	06/30/2016	03/31/2016	06/30/2016	06/30/2016	DY2 Q1

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initializing/maintaining/communicating risk stratification across settings, including means for electronic interfacing to the participating provider community and key data sharing.									
Task 2. MCC vendor solution will include communication channels to track targeted patients in the database for monitoring blood pressure, cholesterol, smoking status, and cardiovascular medications.	Project		Not Started	03/31/2016	06/30/2016	03/31/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3. MCC vendor solution will implement and deploy population health management by leveraging data from the data exchange/HIE environments.	Project		Not Started	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 4. Select pilot test sites for Million Hearts implementation of patient engagement registries.	Project		Not Started	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Review Million Hearts program goals and work with PCMH coordinator to get buy-in to implement as a QI program for PCMH accreditation.	Project		Not Started	09/30/2016	12/31/2016	09/30/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Identify criteria required to develop registry and create patient registries.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 7. Work with identified practices on Million Hearts focused clinical criteria on monitoring registries at PCP offices for care coordination outreach (PCMH Standard 4 requirement) and verify engagement.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 8. Report on patient engagement and engaged safety net practices according to project milestone reporting requirements.	Project		Not Started	10/02/2016	03/31/2017	10/02/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Assess continuous improvement by monitoring clinical quality measures (PCMH Standard 6).	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
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	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate tobacco control protocols.	Project		In Progress	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4

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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	09/01/2015	03/31/2017	09/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Engage NYS Quitline to ensure that resources are available and referral information can be shared with primary care practice staff for referral of patients to community-based smoking cessation resources.	Project		Completed	09/01/2015	12/31/2015	09/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 2. Develop written training materials, resources, list training dates.	Project		Not Started	01/01/2016	03/31/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2
Task 3. Work with Quitline team to offer primary care practice staff trainings on available Quitline resources.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 4. Work with Quitline team to develop training modules for practices (on available patient engagement resources, telephonic motivational coaching, web-based peer coaching, personalized text messaging, and screening for NRT eligibility).	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 5. Promote Opt to Quit™ opt-out policy at practices. Promote integration of Tobacco Use screening workflows (including EHR prompt within practice EHRs to automate completion of 5As of Tobacco control).	Project		Not Started	07/01/2016	12/30/2016	07/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 6. Use EHR to build automated referral processes to facilitate coordination of care and transition through Quitline referrals.	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Integrate tobacco cessation counseling in PCMH 2014 Level 3 accreditation workflow for managing CVD including assessment and monitoring of tobacco use (PCMH Std 3 includes recording comprehensive health assessment, using data in EB decision support).	Project		Not Started	09/01/2016	03/31/2017	09/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Project	N/A	In Progress	09/30/2015	03/31/2017	09/30/2015	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	Project		In Progress	09/30/2015	03/31/2017	09/30/2015	03/31/2017	03/31/2017	DY2 Q4

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(NCEP) or US Preventive Services Task Force (USPSTF).									
Task 1. Request an American Heart Association (AHA) Spotlight Series Speaker offering CME/CE and grand rounds presentation on topics related to cardiovascular disease in a hospital setting in collaboration with partner PPS organizations (FLPPS and CPWNY).	Project		Not Started	04/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2. Define the need to adhere to clinical algorithms in master services agreement (MSA) for all PCPs participating in Domain 3 projects.	Project		Completed	09/30/2015	12/31/2015	09/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task 3. Support MCC PCP partners who have signed MSA by educational detailing to make practices aware of the Million Hearts website resources (patient education web, video tools and printed materials, practice management tools, lifestyle management website resources).	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Define protocols in EHR at participating PCPs to identify patients in the Million Hearts registry.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task 5. Conduct analysis to see if clinical protocols exist and determine if gaps are present.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task 6. Plan to close gaps in workflows and protocols to support patients in the Million Hearts registry at participating sites.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task 7. To close gaps, support MCC PCP partners by educational detailing for decision support tools and treatment algorithms to assess CVD including clinical treatment algorithms/guideline pocket cards for cholesterol, blood pressure, lifestyle management, and obesity management.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task 8. Evaluate the need to offer CME to clinical teams for training related to the use of clinical treatment algorithms to manage blood pressure.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task 9. List all training dates and number of staff trained along with training materials provided.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2

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Task 10. Build MCC partner database to include CBOs with health, wellness, and prevention programs. MCC will document evidence of agreement to allow CBOs to accept warm referrals. Partner database available to all MCC PCP sites and updated on a quarterly basis as new partners are added.	Project		In Progress	10/02/2015	03/31/2017	10/02/2015	03/31/2017	03/31/2017	DY2 Q4
Task 11. Begin providing periodic reports of the clinical quality measures for CVD management to the Clinical/Quality Committee. Work with Practitioner Engagement Liaison to track adoption of protocols that are aligned with national guidelines.	Project		Not Started	10/03/2016	12/30/2016	10/03/2016	12/30/2016	12/31/2016	DY2 Q3
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	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	08/03/2015	03/31/2017	08/03/2015	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	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		In Progress	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. MCC PCMH project lead will identify and recruit a project champion at PCP site to assist with EHR integration to MCC HIE and RHIO for building a clinically interoperable system.	Project		Not Started	01/01/2016	10/21/2016	01/01/2016	10/21/2016	12/31/2016	DY2 Q3
Task 2. MCC PCMH project lead to assist with identifying practice champions at PCP sites to support MHP goals for PCMH Std 4 (care management support). Establish practice level workflows to identify patients in CVD registry, address and record patient goals. Create a list of participating PCP partner sites.	Project		Not Started	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task 3. Build training on BP and LDL management protocols to help identified PCP partners develop workflows and treatment	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1

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protocols for care management. Use AHA-approved protocols and MHP clinical treatment algorithms. List all training dates for offered trainings.									
Task 4. Increase the adoption of standard clinical protocols and treatment plans available for CVD management through MHP.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Provide a list of care coordination resources in the community including community programs such as free or low-cost community wellness classes.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 6. For ongoing care coordination, facilitate a referral process for warm referrals to CBOs (who have signed agreements with MCC) and partners (health home care managers where applicable, pharmacists, dietitians, and community health workers).	Project		Not Started	07/01/2016	12/30/2016	07/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 7. MCC to develop a PPS partner database for coordination resources available outside the practice setting (e.g., CDSMP/Stanford model, tobacco cessation classes, Baby and Me Tobacco Free, nutrition counseling, community cooking classes).	Project		In Progress	09/07/2015	03/31/2016	09/07/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8. MCC PCMH project lead to document workflows to increase referrals to resources such as medication therapy management, dietician referrals, community health workers (and health homes if eligibility requirements are met).	Project		Not Started	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2
Task 9. MCC partner database will be disseminated to practice champions. MCC partner database will contain regional categories of partners, provider type and primary contacts for these referral services. Database will be updated as new partners are engaged	Project		Not Started	04/01/2016	12/30/2016	04/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 10. MCC Clinical Outreach team will support the PCMH project lead in monitoring and tracking the number and location of primary care practices using the team-based care model for managing cardiovascular disease.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		Not Started	03/31/2016	09/30/2016	03/31/2016	09/30/2016	09/30/2016	DY2 Q2

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11. MCC will work with the PCMH project lead to ensure that practices are documenting self management goals in medical record (diet, exercise, medication management, nutrition, etc.).									
Task 12. MCC will collaborate with the RHIO, HEALTHeLINK, to establish a clinically interoperable system for data sharing with participating providers.	Project		In Progress	08/03/2015	03/31/2017	08/03/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Project	N/A	Not Started	10/03/2016	09/30/2017	10/03/2016	09/30/2017	09/30/2017	DY3 Q2
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Provider	Practitioner - Primary Care Provider (PCP)	Not Started	10/03/2016	09/30/2017	10/03/2016	09/30/2017	09/30/2017	DY3 Q2
Task 1. Work on sustainable strategies with the Health Plans for PCP practice sites to offer blood pressure checks to patients without a copayment or appointment.	Project		Not Started	01/02/2017	06/30/2017	01/02/2017	06/30/2017	06/30/2017	DY3 Q1
Task 2. Train care coordination team and other non-clinical practice team members in proper blood pressure measurement technique so patients can obtain drop in blood pressure readings.	Project		Not Started	10/03/2016	12/31/2016	10/03/2016	12/31/2016	12/31/2016	DY2 Q3
Task 3. Work with each participating PCP site to develop EHR alerts to the site if blood pressure check is overdue.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 4. At each practice, update patient registry with blood pressure check dates recorded. Update patient roster at regular intervals to monitor patients at different practice sites who have received follow up blood pressure checks.	Project		Not Started	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task 5. Ask PCP sites to run quarterly reports for patients who have received follow up blood pressure checks	Project		Not Started	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Project	N/A	Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place to ensure blood pressure	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4

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measurements are taken correctly with the correct equipment.									
Task 1. Practice-wide policy instituted to ensure that practice staff are trained in BP measurement. MCC Clinical Outreach team to build workflow to recheck BP reading and establish future interventions/self management goals if blood pressure above goal.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. To track accurate measurement of blood pressure by staff, workflows will be established within the practice to alert team members about patterns of high blood pressure taken by support team.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Offer CME to coordination team members for blood pressure measurement technique, AHA guidelines for BP management, and develop training protocol for BP measurement. List of training dates and staff in attendance for all trainings.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	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	Not Started	10/03/2016	09/30/2017	10/03/2016	09/30/2017	09/30/2017	DY3 Q2
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Project		Not Started	10/03/2016	09/30/2017	10/03/2016	09/30/2017	09/30/2017	DY3 Q2
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		Not Started	10/03/2016	09/30/2017	10/03/2016	09/30/2017	09/30/2017	DY3 Q2
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	Project		Not Started	10/03/2016	09/30/2017	10/03/2016	09/30/2017	09/30/2017	DY3 Q2
Task 1. Create process to monitor in PPS patient database, targeted registry for patients at PCP offices with elevated BP (SBP >140 mmHg and DBP >90 mmHg) but no diagnosis of hypertension (indicated in the medical record).	Project		Not Started	10/03/2016	12/31/2016	10/03/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. Work with PCP champion identified at each practice site on workflows for team to identify, target, and schedule appointment	Project		Not Started	12/31/2016	03/31/2017	12/31/2016	03/31/2017	03/31/2017	DY2 Q4

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for patients with repeated elevated BP (SBP >140 mmHg and DBP >90 mmHg) but no diagnosis of hypertension is indicated in the medical record.									
Task 3. Offer training to staff to ensure effective patient identification and visit scheduling for documentation of hypertension visit. List all training dates and number of staff trained along with written training materials provided.	Project		Not Started	04/01/2017	09/30/2017	04/01/2017	09/30/2017	09/30/2017	DY3 Q2
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	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		Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. MCC Clinical Outreach team working with the PCP should ensure that a medical management policy is in place for primary care practice partners.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2. Get list of PCP offices with signed medical management policy.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 3. Policy should include adoption of workflows on medication adherence/reminders, potential side effects of medication, prescription of medications included in patient covered formulary, fixed dose combination pills or once daily regimen (if possible to promote medication adherence), refill strategy to manage medication refills as necessary.	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 4. Run a query using MCC HIE solution for Rx claims data for each PCP site to identify list of PCP offices instituting medical management policy.	Project		Not Started	06/30/2016	09/30/2016	06/30/2016	09/30/2016	09/30/2016	DY2 Q2
Task 5. Obtain a list of participating PCPs who have not prescribed once-daily regimens or fixed combination therapy for MCC recipients.	Project		Not Started	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 6. Set up appointments at each PCP site to review results on an	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

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annual basis. Record all dates for medication review and report annually to the Clinical/Quality Committee.									
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	Not Started	01/01/2016	12/29/2017	01/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task Self-management goals are documented in the clinical record.	Project		Not Started	01/01/2016	12/29/2017	01/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	Project		Not Started	01/01/2016	12/29/2017	01/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task 1. MCC Clinical Outreach team will help develop web-based training modules on PCMH Stds for PCP partners (non-safety net and safety net PCP). Training module includes documenting patient self-engagement goals and periodic self audit.	Project		Not Started	01/01/2016	12/30/2016	01/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 2. Work with MCC Clinical Director to identify PCMH practices seeking PCMH accreditation and interested in adopting Million Hearts as the Quality Improvement program.	Project		Not Started	01/01/2016	12/30/2016	01/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 3. Create a list of practices using the Million Hearts program and conduct a needs assessment to determine gaps in each practice for processes, clinical tools and workflows.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 4. Use findings from Needs Assessment to support MCC PCMH lead in implementation of MHP interventions for PCMH Std 4 - Care Management measures. (PCMH Measure 4 Element B includes practice team documenting patient self-management goals in the EHR.)	Project		Not Started	10/03/2016	12/30/2016	10/03/2016	12/30/2016	12/31/2016	DY2 Q3
Task 5. Monitor PCMH accreditation process and workflows to incorporate MH protocols and processes at determined PCP sites.	Project		Not Started	01/01/2017	12/29/2017	01/01/2017	12/29/2017	12/31/2017	DY3 Q3
Task 6. Use EHR to establish registries of patients eligible for the MH interventions and monitor documentation required (self-management goals in the medical record) to meet requirements for Patient Engagement Speed.	Project		Not Started	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task	Project		Not Started	07/04/2016	03/31/2017	07/04/2016	03/31/2017	03/31/2017	DY2 Q4

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7. A list of resources to support the patient's self-management goals should be offered and noted in the medical record. May include referrals for CDSMP/Stanford Model, tobacco cessation resources, nutrition counseling, and community cooking classes.									
Task 8. MCC Clinical Outreach team will periodically facilitate training on motivational interviewing strategies to improve patient self-management.	Project		Not Started	10/03/2016	06/30/2017	10/03/2016	06/30/2017	06/30/2017	DY3 Q1
Task 9. A list of training dates and staff trained should be maintained by the PPS and reported periodically to the practice engagement team.	Project		Not Started	10/03/2016	09/30/2017	10/03/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Project	N/A	Not Started	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task PPS has developed referral and follow-up process and adheres to process.	Project		Not Started	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		Not Started	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Project		Not Started	04/01/2016	09/30/2017	04/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task 1. MCC will document evidence of agreement with CBOs. Partner database list will be available to MCC PCP sites.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. If patient is eligible for health home, MCC clinical outreach team will work with PCP practices on a workflow or warm referrals to health homes.	Project		Not Started	01/02/2017	09/29/2017	01/02/2017	09/29/2017	09/30/2017	DY3 Q2
Task 3. Maintain a list of MCC PCP sites who have established a process for warm referrals.	Project		Not Started	06/30/2016	09/29/2017	06/30/2016	09/29/2017	09/30/2017	DY3 Q2
Task 4. Develop process to track referrals made to community-based programs and health homes by MCC PCP practices.	Project		Not Started	09/30/2016	12/30/2016	09/30/2016	12/30/2016	12/31/2016	DY2 Q3

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Task 5. Practices will be provided with an MCC partner database for direct referral for CBO services (for patients who may not be eligible for health home interventions).	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Train practices on making warm referrals to health homes and CBOs. Maintain list of training dates for each PCP site.	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. MCC clinical outreach team will provide written training materials on making warm referrals.	Project		Not Started	09/30/2016	03/31/2017	09/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Evaluate and track warm referrals made by each MCC PCP practice to health homes and/or community based organizations every quarter. Review count of referrals made to CBOs to facilitate feedback. Report to Clinical/Quality Committee on count of warm referrals made to CBOs and health homes by PCP practice sites.	Project		Not Started	03/31/2017	09/30/2017	03/31/2017	09/30/2017	09/30/2017	DY3 Q2
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Project	N/A	Not Started	01/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.	Project		Not Started	01/01/2016	03/31/2017	04/01/2016	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		Not Started	01/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		Not Started	01/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify which MCOs in the MCC network cover the majority of the attributed members and work with the benefit managers of these plans to promote coverage for validated Self Monitoring of Blood Pressure (SMBP) monitors.	Project		Not Started	01/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. MCC Clinical Outreach team will identify and work with academic detailers to support primary care practice team on securing and using SMBP monitors.	Project		Not Started	01/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3

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Task 3. MCC Clinical outreach team to facilitate trainings for PCP team to teach cuff selection, patient positioning, measurement without talking, and accurate blood pressure observation.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 4. Trainings for the practice team on ways to support self monitoring including educating patients about the importance of self monitoring for BP, training patient on using the device, and providing BP logs to the care team.	Project		Not Started	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 5. Development of workflows and policies to support patients on self monitoring of BP at home: during follow up visits, PCP team will review patient SMBP readings, request medication fills, provide summaries of clinic visits.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. MCC clinical outreach team will support staff on referral mechanisms for ongoing patient outreach support and follow up if blood pressure results above goal through periodic recording of self-recorded BP.	Project		Not Started	04/01/2016	12/30/2016	04/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 7. Support for the PCP team to include resources for patient referrals to community classes for lifestyle management (CDSMP/Stanford model programs, dietician referrals, Quitline resources, and medication therapy education).	Project		Not Started	04/01/2016	12/30/2016	04/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 8. PCP team trainings on protocols to review patient support tools (such as written information or videos on how to self monitor blood pressure, a contact for patients at the practice to call with questions).	Project		Not Started	04/01/2016	12/30/2016	04/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 9. Clinical outreach team to support PCP practice staff through training for protocols during follow up visits including reviewing patient SMBP readings, requesting medication fills, providing summaries of clinic visits.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. List training dates and number of MCC PCP partners attending training sessions. Record all additional resources provided to trainees including a list of community based classes available through the MCC Partner Database.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Task 11. Work with MCC vendor solution to build alerts into patient registry for patients diagnosed with high blood pressure but no documentation of recent PCP visit in rolling six-month timeframe.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Project	N/A	Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. MCC clinical outreach team schedule training sessions for primary care practice team on workflows to outreach to roster of identified patients who need to schedule a follow up visit.	Project		Not Started	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task 2. MCC Clinical outreach team help develop workflows for (a) reminder calls for follow up visit and (b) a system to connect with external MCC care coordination team (community health workers) to engage patients if practice is unsuccessful in telephonic outreach.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. MCC will document list of practices trained on scheduling follow up visit.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Documentation of patients engaged through a follow up visit to manage their hypertension will be recorded in the vendor system.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. MCC will collaborate with Health Systems Centers for a Tobacco Free WNY (Roswell Park) to assist in creation and adoption of policies and programs to help patients quit using tobacco products.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2. Maintain a list of MCC PCP sites participating in the Million	Project		Not Started	06/30/2016	12/30/2016	06/30/2016	12/30/2016	12/31/2016	DY2 Q3

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Hearts program to target for ongoing training on warm referrals.									
Task 3. Facilitate training sessions for MCC primary care practice partners on available NYS Quitline cessation resources.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 4. Implement training at participating MCC PCP sites (on NYS Quitline and cessation services offered through the program). Maintain a list primary care practice sites trained in making warm referrals.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. MCC will monitor a list of PCP sites demonstrating evidence of warm referrals to the NYS Quitline.	Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 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	10/02/2015	09/30/2017	10/02/2015	09/30/2017	09/30/2017	DY3 Q2
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	10/02/2015	09/30/2017	10/02/2015	09/30/2017	09/30/2017	DY3 Q2
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	10/02/2015	09/30/2017	10/02/2015	09/30/2017	09/30/2017	DY3 Q2
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	10/02/2015	09/30/2017	10/02/2015	09/30/2017	09/30/2017	DY3 Q2
Task 1. MCC to implement collection of REAL (Race Ethnicity and Language) data via the EHR vendor systems of MCC PCP partners. REAL data collection is critical for Population Health in 2014 Level 3 PCMH Std and MU Stage 2 core requirement.	Project		Not Started	01/02/2017	06/30/2017	01/02/2017	06/30/2017	06/30/2017	DY3 Q1
Task 2. Demographic information and REAL data are collected as structured data to be imported into the MCC Population Health management system to target high risk populations.	Project		Not Started	01/02/2017	06/30/2017	01/02/2017	06/30/2017	06/30/2017	DY3 Q1
Task 3. REAL data collected will be used by MCC in understanding	Project		Not Started	01/02/2017	06/30/2017	01/02/2017	06/30/2017	06/30/2017	DY3 Q1

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health education needs in "hot spot" areas.									
Task 4. REAL data collection will guide MCC population health program delivery and education through partnering with cultural CBOs in hot spot areas.	Project		Not Started	04/03/2017	09/30/2017	04/03/2017	09/30/2017	09/30/2017	DY3 Q2
Task 5. REAL data collection will help MCC connect PCP practices to local MCC cultural CBO partners. MCC to maintain documentation of training support including written training materials and training dates along with number of staff trained.	Project		Not Started	04/03/2017	09/30/2017	04/03/2017	09/30/2017	09/30/2017	DY3 Q2
Task 6. If patient is eligible for health home services, MCC Clinical Outreach Team will work with PCP practices on workflows for warm referrals to Health Homes.	Project		Not Started	10/03/2016	09/30/2017	10/03/2016	09/30/2017	09/30/2017	DY3 Q2
Task 7. The warm referral to Health Home Case management will leverage information from the RHIO, HEALTHeLINK.	Project		Not Started	01/02/2017	09/30/2017	01/02/2017	09/30/2017	09/30/2017	DY3 Q2
Task 8. The referral process will secure complete and signed PHI disclosure for referral to Health Home Case management.	Project		Not Started	01/02/2017	09/30/2017	01/02/2017	09/30/2017	09/30/2017	DY3 Q2
Task 9. Training dates will be recorded along with the number of primary care practice staff and trained in making linkages to health homes for care coordination. All trainings will be reported to the Practice Engagement team.	Project		Not Started	10/03/2016	09/30/2017	10/03/2016	09/30/2017	09/30/2017	DY3 Q2
Task 10. MCC Partner Database to list all CDSMP/Stanford Model CBO sites.	Project		In Progress	10/02/2015	09/30/2016	10/02/2015	09/30/2016	09/30/2016	DY2 Q2
Task 11. Community program sites listed by county and region are available through the NY State Health Data. Program training for the Stanford model is available through the New York State Quality and Technical Assistance Center (NYS _QTAC).	Project		In Progress	10/02/2015	09/30/2017	10/02/2015	09/30/2017	09/30/2017	DY3 Q2
Task 12. For ongoing care coordination, facilitate a referral process for warm referrals to CBOs (who have signed agreements with MCC) to enroll patients in CDSMP/Stanford Model.	Project		Not Started	10/03/2016	06/30/2017	10/03/2016	06/30/2017	06/30/2017	DY3 Q1
Task 13. MCC will provide training on the referral process and written	Project		Not Started	04/03/2017	09/30/2017	04/03/2017	09/30/2017	09/30/2017	DY3 Q2

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training materials on available CDSMP resources , program locations, how to explain the program to patients, and how to refer patients to the programs.									
Task 14. MCC will record all training dates and number of staff trained along with written training materials provided to the primary care practice teams. All trainings will be reported to the Practice Engagement team.	Project		Not Started	04/03/2017	09/30/2017	04/03/2017	09/30/2017	09/30/2017	DY3 Q2
Milestone #18 Adopt strategies from the Million Hearts Campaign.	Project	N/A	Not Started	01/01/2016	03/31/2017	01/01/2016	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	Practitioner - Primary Care Provider (PCP)	Not Started	01/01/2016	03/31/2017	01/01/2016	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	Practitioner - Non-Primary Care Provider (PCP)	Not Started	01/01/2016	03/31/2017	01/01/2016	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	Mental Health	Not Started	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 1. MCC will identify PCP sites and maintain a list of sites implementing the four main program components of MHP. The MHP initiatives will be used to meet PCMH 2014 level 3 Std 4 (care management of chronic conditions) and Std 6 (Evaluating quality improvement).	Project		Not Started	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 2. PCMH lead will work with sites to create a workflow that includes identification, tracking, and outreach for patients with a diagnosis of hypertension and who have not had a PCP visit within the last six months. PCMH lead will maintain a list of all PCP sites trained in workflow implementation.	Project		Not Started	01/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 3. Policies and workflows developed will ensure that patients are contacted to confirm appointments and instructed to bring in all their medication for review at their appointment.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4

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Task 4. Policies will be established to record BP measurement at each PCP visit as well as screen patients for cholesterol and tobacco use according to the MHP.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. The workflow will detail monitoring patients with vascular disease for Aspirin use. Patients at high risk for ASCVD using the risk calculator tool will be treated according to goal based on the established treatment guidelines.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. A self management plan will be provided to each patient at the end of each office visit.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 7. Training will be offered to PCP staff on warm transfers to MCC CBOs on customized self management support for lifestyle changes (CDSMP Programs), medication adherence, NYS Quitline, and other resources as needed.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 8. Workflows will detail warm transfer to MCC CBO partners for ongoing MCC CBO support and documentation of referrals made.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Written training materials will also be provided: training to the clinical care coordination team on BP measurement, motivational interviewing strategies, and workflows for warm transfer of patients for ongoing community support.	Project		Not Started	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task 10. Training will be provided to MCC partners on accepting a warm transfer from the primary care practices.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 11. All trainings dates and locations will be recorded and a list of trainings dates and written materials provided will be reported to the Practice Engagement Team on an ongoing basis.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
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	09/01/2015	09/30/2017	09/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS has agreement in place with MCO related to coordination of	Project		In Progress	09/01/2015	09/30/2017	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.									
Task 1. Assess ability to contract with MCOs for coordination of services (hypertension screening, smoking cessation referral, cholesterol screening and other preventative services) related to CVD management.	Project		Not Started	09/01/2015	12/31/2015	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 2. Elicit input from MCOs on elements of a multi-year plan to transition to VBP system; present proposed plan (including coordination of services for high-risk populations) to MCOs.	Project		Not Started	12/31/2015	03/31/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 3. Explain to MCOs the goals for managing high-risk population through collaboration: a) educating providers on MHP components, b) support implementation of MHP to manage patients for Level 3 2014 PCMH accreditation, c) refer patients to MCC CBO partners.	Project		Not Started	12/31/2015	03/31/2016	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 4. Seek MCOs' revisions and approval of plan to coordinate services under this project. Catalog the main issues and data needs necessary for resolution as a part of the plan approval process.	Project		Not Started	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Establish incentives based on utilization and quality metrics related to managing cardiovascular disease in the affected Medicaid population.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 6. Use the VBP transition plan to guide agenda in monthly MCO meetings.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 7. Obtain signed agreement with MCOs and list dates of signed agreements. Medicaid Managed care metrics and opportunities reported to MCC Board of Manager committees.	Project		Not Started	04/03/2017	09/30/2017	04/03/2017	09/30/2017	09/30/2017	DY3 Q2
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Project	N/A	Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Practitioner - Primary	Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
		Care Provider (PCP)							
Task 1. Design project goals, interventions, metrics, and reporting measures; work with PCMH coordinator to implement these interventions as a part of the QI standards (Standard 6) required for Level 3 PCMH certification.	Project		Not Started	04/01/2016	12/30/2016	04/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 2. Create a list of providers engaged in PCMH accreditation using the Million Hearts Quality Improvement Program.	Project		Not Started	04/01/2016	12/30/2016	04/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 3. Assess percentage of providers engaged using the Million Hearts/Cardiovascular disease management as a QI project for Level 3 PCMH certification.	Project		Not Started	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 4. Work with Clinical Outreach team and PCMH practice engagement coordinator to implement MH interventions and record staff trainings. Provide MCC Partner database of community resources as a continued resource.	Project		Not Started	04/01/2016	12/30/2016	04/01/2016	12/30/2016	12/31/2016	DY2 Q3
Task 5. Establish quarterly touch points to PCP to communicate with providers on a) Performance measures related to the MHP, b) ongoing management as a QI program for Standard 6 Level 3 PCMH accreditation, and c) referral of patients to community resources.	Project		Not Started	10/03/2016	03/31/2017	10/03/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Determine number of MCC PCP sites engaged in Million Hearts and conduct annual reviews to identify new PCP sites for ongoing support/outreach/training until 80 % of PCPs are engaged.	Project		Not Started	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement 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										

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ambulatory and community care setting.										
Task 1. Develop comprehensive MCC partner database for MCC partners included in the management of CVD. Partner database will categorize partners by provider type (including ambulatory care or community care partner) and demonstrate changes to the network list.										
Task 2. Collect appropriate clinical tools necessary for the different goals of the Million Hearts Program (MHP): blood pressure guidelines, cholesterol management guidelines, and the tools for smoking cessation.										
Task 3. Disseminate written evidence-based treatment protocols for managing CVD using the techniques and resources provided on the Million Hearts Campaign program website.										
Task 4. Define priority target population, and develop a framework for patient database to include risk stratified registries and blood pressure measurements.										
Task 5. Identify pilot PCP sites to implement MHP.										
Task 6. Meet with each practice site on identified list.										
Task 7. List all PCP sites that plan on using Million Hearts registries and work on process flows at each PCP site to manage CVD population using Million Hearts criteria.										
Task 8. Develop process and identify vendor for patient registry/database development. Vendor to interface with data points available through the regional RHIO (HEALTHeLINK) to integrate information from disparate EHRs from primary care offices.										
Task 9. Pilot test patient database to integrate EHR data points from a variety of Primary Care offices relevant to risk stratification, blood pressure, and cardiovascular medications.										
Task 10. Track and monitor patient engagement at each PCP practice site and build quarterly performance metrics related to the four program areas in Million Hearts to verify continuous improvement.										

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Task 11. Begin reporting on implementation of project requirements quarterly according to project milestone reporting requirements.										
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	2	6	10	20	30	40	50	60	80
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	5	10	15	20	25	30
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	10	20	30	40	50	55	60
Task PPS uses alerts and secure messaging functionality.										
Task 1. Conduct gap analysis to determine which providers have already completed PCMH/MU or other connectivity readiness assessment. Include the following questions: Is the practice/providers/patients currently connected to the HIE? If not, is an agreement in place? If so, what is the scope of the connectivity (% of providers; % of patients)? Does EHR meet connectivity requirements of RHIO/SHIN-NY? Name of EHR, version, and electronic functionalities in use										
Task 2. Develop strategy for low-cost data connectivity between ISPs (e.g., WNY R-AHEC) and local practice plans to determine minimum hardware and software requirements.										
Task 3. Gather results from readiness assessments already conducted.										
Task 4. Issue request for applications (RFA) or other action step for readiness assessment and transformation support services.										
Task 5. Select vendor or implement other structure for readiness assessment and transformation support services.										
Task 6. Identify funding model and/or PPS provider incentive model for										

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EHR with the Finance Committee.										
Task 7. Connect PPS providers to MCC enterprise DSRIP solution.										
Task 8. Implement enterprise DSRIP solution and start data exchange.										
Task 9. Implement PPS providers in waves grouped by the partner's ability to connect and integrate into the solution; start with the most able to connect; add others as they establish their capabilities.										
Task 10. Systematically contact PPS providers to provide the recommended enterprise DSRIP solution.										
Task 11. Facilitate QE participation agreements with MCC providers.										
Task 12. Implement and deploy patient record look-up training.										
Task 13. Implement and deploy MCC DSRIP dashboard reporting capabilities. Provide EHR vendor documentation, screenshots, and/or samples of transactions to public health registries. Designate experts at each PCP site for ongoing support.										
Task 14. Implement and deploy alerts. Provide EHR vendor documentation, screenshots, and/or evidence of use of alerts.										
Task 15. Implement and deploy secure Direct messaging. Provide EHR vendor documentation, screenshots, and/or evidence of use of secure Direct messaging.										
Task 16. Continuously add MCC providers when their EHR and data exchange capabilities reach the minimal level required to connect to the MCC EHR and data exchange/HIE.										
Task 17. Maintain list of all PPS safety net providers with secure Direct messaging capabilities who completed training. Report to Physician Performance Sub-Committee.										
Task 18. MCC providers who are not actively exchanging systems will be reviewed by the Physician Performance Sub-Committee. Corrective actions will be implemented for those members found noncompliant.										
Milestone #3 Ensure that EHR systems used by participating safety net										

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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	2	5	10	15	27	52	92	200	300
Task 1. Conduct Safety Net MU stage 2 CMS/PCMH level 3 readiness assessment: (a) identify site-specific IT/care management leadership, (b) determine current EHR PCMH/MU certification status, and (c) identify site-specific barriers and risks to implementing a MU/PCMH Level 3 certified EHR system.										
Task 2. Facilitate engagement with MU/PCMH-certified EHR vendors as needed.										
Task 3. Establish PCMH/MU project implementation plan based on primary care practice readiness and certification status.										
Task 4. Review PCMH implementation plan for approval by the Clinical/Quality Committee.										
Task 5. Ensure practices have support through the PCMH implementation process either through a vendor or through MCC PCMH coordinators.										
Task 6. Establish a monthly review and measurement process of implementation progress and report to Clinical/Quality Committee.										
Task 7. Modify implementation plan as needed based on monthly review process.										
Task 8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.										
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.										

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Task 1. Define IT requirements for initializing/maintaining/communicating risk stratification across settings, including means for electronic interfacing to the participating provider community and key data sharing.										
Task 2. MCC vendor solution will include communication channels to track targeted patients in the database for monitoring blood pressure, cholesterol, smoking status, and cardiovascular medications.										
Task 3. MCC vendor solution will implement and deploy population health management by leveraging data from the data exchange/HIE environments.										
Task 4. Select pilot test sites for Million Hearts implementation of patient engagement registries.										
Task 5. Review Million Hearts program goals and work with PCMH coordinator to get buy-in to implement as a QI program for PCMH accreditation.										
Task 6. Identify criteria required to develop registry and create patient registries.										
Task 7. Work with identified practices on Million Hearts focused clinical criteria on monitoring registries at PCP offices for care coordination outreach (PCMH Standard 4 requirement) and verify engagement.										
Task 8. Report on patient engagement and engaged safety net practices according to project milestone reporting requirements.										
Task 9. Assess continuous improvement by monitoring clinical quality measures (PCMH Standard 6).										
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.										

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Task 1. Engage NYS Quitline to ensure that resources are available and referral information can be shared with primary care practice staff for referral of patients to community-based smoking cessation resources.										
Task 2. Develop written training materials, resources, list training dates.										
Task 3. Work with Quitline team to offer primary care practice staff trainings on available Quitline resources.										
Task 4. Work with Quitline team to develop training modules for practices (on available patient engagement resources, telephonic motivational coaching, web-based peer coaching, personalized text messaging, and screening for NRT eligibility).										
Task 5. Promote Opt to Quit™ opt-out policy at practices. Promote integration of Tobacco Use screening workflows (including EHR prompt within practice EHRs to automate completion of 5As of Tobacco control).										
Task 6. Use EHR to build automated referral processes to facilitate coordination of care and transition through Quitline referrals.										
Task 7. Integrate tobacco cessation counseling in PCMH 2014 Level 3 accreditation workflow for managing CVD including assessment and monitoring of tobacco use (PCMH Std 3 includes recording comprehensive health assessment, using data in EB decision support).										
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. Request an American Heart Association (AHA) Spotlight Series Speaker offering CME/CE and grand rounds presentation on topics related to cardiovascular disease in a hospital setting in collaboration with partner PPS organizations (FLPPS and CPWNY).										
Task										

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2. Define the need to adhere to clinical algorithms in master services agreement (MSA) for all PCPs participating in Domain 3 projects.										
Task 3. Support MCC PCP partners who have signed MSA by educational detailing to make practices aware of the Million Hearts website resources (patient education web, video tools and printed materials, practice management tools, lifestyle management website resources).										
Task 4. Define protocols in EHR at participating PCPs to identify patients in the Million Hearts registry.										
Task 5. Conduct analysis to see if clinical protocols exist and determine if gaps are present.										
Task 6. Plan to close gaps in workflows and protocols to support patients in the Million Hearts registry at participating sites.										
Task 7. To close gaps, support MCC PCP partners by educational detailing for decision support tools and treatment algorithms to assess CVD including clinical treatment algorithms/guideline pocket cards for cholesterol, blood pressure, lifestyle management, and obesity management.										
Task 8. Evaluate the need to offer CME to clinical teams for training related to the use of clinical treatment algorithms to manage blood pressure.										
Task 9. List all training dates and number of staff trained along with training materials provided.										
Task 10. Build MCC partner database to include CBOs with health, wellness, and prevention programs. MCC will document evidence of agreement to allow CBOs to accept warm referrals. Partner database available to all MCC PCP sites and updated on a quarterly basis as new partners are added.										
Task 11. Begin providing periodic reports of the clinical quality measures for CVD management to the Clinical/Quality Committee. Work with Practitioner Engagement Liaison to track adoption of protocols that are aligned with national guidelines.										
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers 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
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. MCC PCMH project lead will identify and recruit a project champion at PCP site to assist with EHR integration to MCC HIE and RHIO for building a clinically interoperable system.										
Task 2. MCC PCMH project lead to assist with identifying practice champions at PCP sites to support MHP goals for PCMH Std 4 (care management support). Establish practice level workflows to identify patients in CVD registry, address and record patient goals. Create a list of participating PCP partner sites.										
Task 3. Build training on BP and LDL management protocols to help identified PCP partners develop workflows and treatment protocols for care management. Use AHA-approved protocols and MHP clinical treatment algorithms. List all training dates for offered trainings.										
Task 4. Increase the adoption of standard clinical protocols and treatment plans available for CVD management through MHP.										
Task 5. Provide a list of care coordination resources in the community including community programs such as free or low-cost community wellness classes.										
Task 6. For ongoing care coordination, facilitate a referral process for warm referrals to CBOs (who have signed agreements with MCC) and partners (health home care managers where applicable, pharmacists, dietitians, and community health workers).										
Task 7. MCC to develop a PPS partner database for coordination resources available outside the practice setting (e.g., CDSMP/Stanford model, tobacco cessation classes, Baby and Me Tobacco Free, nutrition counseling, community cooking classes).										

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Task 8. MCC PCMH project lead to document workflows to increase referrals to resources such as medication therapy management, dietician referrals, community health workers (and health homes if eligibility requirements are met).										
Task 9. MCC partner database will be disseminated to practice champions. MCC partner database will contain regional categories of partners, provider type and primary contacts for these referral services. Database will be updated as new partners are engaged										
Task 10. MCC Clinical Outreach team will support the PCMH project lead in monitoring and tracking the number and location of primary care practices using the team-based care model for managing cardiovascular disease.										
Task 11. MCC will work with the PCMH project lead to ensure that practices are documenting self management goals in medical record (diet, exercise, medication management, nutrition, etc.).										
Task 12. MCC will collaborate with the RHIO, HEALTHeLINK, to establish a clinically interoperable system for data sharing with participating providers.										
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.										
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	0	0	5	10	15	27	52	92	200	300
Task 1. Work on sustainable strategies with the Health Plans for PCP practice sites to offer blood pressure checks to patients without a copayment or appointment.										
Task 2. Train care coordination team and other non-clinical practice team members in proper blood pressure measurement technique so patients can obtain drop in blood pressure readings.										
Task 3. Work with each participating PCP site to develop EHR alerts to the site if blood pressure check is overdue.										
Task 4. At each practice, update patient registry with blood pressure check dates recorded. Update patient roster at regular intervals to monitor patients at different practice sites who have received										

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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
follow up blood pressure checks.										
Task 5. Ask PCP sites to run quarterly reports for patients who have received follow up blood pressure checks										
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. Practice-wide policy instituted to ensure that practice staff are trained in BP measurement. MCC Clinical Outreach team to build workflow to recheck BP reading and establish future interventions/self management goals if blood pressure above goal.										
Task 2. To track accurate measurement of blood pressure by staff, workflows will be established within the practice to alert team members about patterns of high blood pressure taken by support team.										
Task 3. Offer CME to coordination team members for blood pressure measurement technique, AHA guidelines for BP management, and develop training protocol for BP measurement. List of training dates and staff in attendance for all trainings.										
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. Create process to monitor in PPS patient database, targeted registry for patients at PCP offices with elevated BP (SBP >140										

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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
mmHg and DBP >90 mmHg) but no diagnosis of hypertension (indicated in the medical record).										
Task 2. Work with PCP champion identified at each practice site on workflows for team to identify, target, and schedule appointment for patients with repeated elevated BP (SBP >140 mmHg and DBP >90 mmHg) but no diagnosis of hypertension is indicated in the medical record.										
Task 3. Offer training to staff to ensure effective patient identification and visit scheduling for documentation of hypertension visit. List all training dates and number of staff trained along with written training materials provided.										
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. MCC Clinical Outreach team working with the PCP should ensure that a medical management policy is in place for primary care practice partners.										
Task 2. Get list of PCP offices with signed medical management policy.										
Task 3. Policy should include adoption of workflows on medication adherence/reminders, potential side effects of medication, prescription of medications included in patient covered formulary, fixed dose combination pills or once daily regimen (if possible to promote medication adherence), refill strategy to manage medication refills as necessary.										
Task 4. Run a query using MCC HIE solution for Rx claims data for each PCP site to identify list of PCP offices instituting medical management policy.										
Task 5. Obtain a list of participating PCPs who have not prescribed once-daily regimens or fixed combination therapy for MCC recipients.										
Task 6. Set up appointments at each PCP site to review results on an annual basis. Record all dates for medication review and report										

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annually to the Clinical/Quality Committee.										
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. MCC Clinical Outreach team will help develop web-based training modules on PCMH Stds for PCP partners (non-safety net and safety net PCP). Training module includes documenting patient self-engagement goals and periodic self audit.										
Task 2. Work with MCC Clinical Director to identify PCMH practices seeking PCMH accreditation and interested in adopting Million Hearts as the Quality Improvement program.										
Task 3. Create a list of practices using the Million Hearts program and conduct a needs assessment to determine gaps in each practice for processes, clinical tools and workflows.										
Task 4. Use findings from Needs Assessment to support MCC PCMH lead in implementation of MHP interventions for PCMH Std 4 - Care Management measures. (PCMH Measure 4 Element B includes practice team documenting patient self-management goals in the EHR.)										
Task 5. Monitor PCMH accreditation process and workflows to incorporate MH protocols and processes at determined PCP sites.										
Task 6. Use EHR to establish registries of patients eligible for the MH interventions and monitor documentation required (self-management goals in the medical record) to meet requirements for Patient Engagement Speed.										
Task 7. A list of resources to support the patient's self-management goals should be offered and noted in the medical record. May include referrals for CDSMP/Stanford Model, tobacco cessation resources, nutrition counseling, and community cooking classes.										
Task 8. MCC Clinical Outreach team will periodically facilitate training										

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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
on motivational interviewing strategies to improve patient self-management.										
Task 9. A list of training dates and staff trained should be maintained by the PPS and reported periodically to the practice engagement team.										
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. MCC will document evidence of agreement with CBOs. Partner database list will be available to MCC PCP sites.										
Task 2. If patient is eligible for health home, MCC clinical outreach team will work with PCP practices on a workflow or warm referrals to health homes.										
Task 3. Maintain a list of MCC PCP sites who have established a process for warm referrals.										
Task 4. Develop process to track referrals made to community-based programs and health homes by MCC PCP practices.										
Task 5. Practices will be provided with an MCC partner database for direct referral for CBO services (for patients who may not be eligible for health home interventions).										
Task 6. Train practices on making warm referrals to health homes and CBOs. Maintain list of training dates for each PCP site.										
Task 7. MCC clinical outreach team will provide written training materials on making warm referrals.										
Task										

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8. Evaluate and track warm referrals made by each MCC PCP practice to health homes and/or community based organizations every quarter. Review count of referrals made to CBOs to facilitate feedback. Report to Clinical/Quality Committee on count of warm referrals made to CBOs and health homes by PCP practice sites.										
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. Identify which MCOs in the MCC network cover the majority of the attributed members and work with the benefit managers of these plans to promote coverage for validated Self Monitoring of Blood Pressure (SMBP) monitors.										
Task 2. MCC Clinical Outreach team will identify and work with academic detailers to support primary care practice team on securing and using SMBP monitors.										
Task 3. MCC Clinical outreach team to facilitate trainings for PCP team to teach cuff selection, patient positioning, measurement without talking, and accurate blood pressure observation.										
Task 4. Trainings for the practice team on ways to support self monitoring including educating patients about the importance of self monitoring for BP, training patient on using the device, and providing BP logs to the care team.										
Task 5. Development of workflows and policies to support patients on self monitoring of BP at home: during follow up visits, PCP team will review patient SMBP readings, request medication fills, provide summaries of clinic visits.										
Task 6. MCC clinical outreach team will support staff on referral mechanisms for ongoing patient outreach support and follow up if										

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blood pressure results above goal through periodic recording of self-recorded BP.										
Task 7. Support for the PCP team to include resources for patient referrals to community classes for lifestyle management (CDSMP/Stanford model programs, dietician referrals, Quitline resources, and medication therapy education).										
Task 8. PCP team trainings on protocols to review patient support tools (such as written information or videos on how to self monitor blood pressure, a contact for patients at the practice to call with questions).										
Task 9. Clinical outreach team to support PCP practice staff through training for protocols during follow up visits including reviewing patient SMBP readings, requesting medication fills, providing summaries of clinic visits.										
Task 10. List training dates and number of MCC PCP partners attending training sessions. Record all additional resources provided to trainees including a list of community based classes available through the MCC Partner Database.										
Task 11. Work with MCC vendor solution to build alerts into patient registry for patients diagnosed with high blood pressure but no documentation of recent PCP visit in rolling six-month timeframe.										
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. MCC clinical outreach team schedule training sessions for primary care practice team on workflows to outreach to roster of identified patients who need to schedule a follow up visit.										
Task 2. MCC Clinical outreach team help develop workflows for (a) reminder calls for follow up visit and (b) a system to connect with external MCC care coordination team (community health workers) to engage patients if practice is unsuccessful in telephonic outreach.										
Task 3. MCC will document list of practices trained on scheduling follow up visit.										

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Task 4. Documentation of patients engaged through a follow up visit to manage their hypertension will be recorded in the vendor system.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task 1. MCC will collaborate with Health Systems Centers for a Tobacco Free WNY (Roswell Park) to assist in creation and adoption of policies and programs to help patients quit using tobacco products.										
Task 2. Maintain a list of MCC PCP sites participating in the Million Hearts program to target for ongoing training on warm referrals.										
Task 3. Facilitate training sessions for MCC primary care practice partners on available NYS Quitline cessation resources.										
Task 4. Implement training at participating MCC PCP sites (on NYS Quitline and cessation services offered through the program). Maintain a list primary care practice sites trained in making warm referrals.										
Task 5. MCC will monitor a list of PCP sites demonstrating evidence of warm referrals to the NYS Quitline.										
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. MCC to implement collection of REAL (Race Ethnicity and										

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Language) data via the EHR vendor systems of MCC PCP partners. REAL data collection is critical for Population Health in 2014 Level 3 PCMH Std and MU Stage 2 core requirement.										
Task 2. Demographic information and REAL data are collected as structured data to be imported into the MCC Population Health management system to target high risk populations.										
Task 3. REAL data collected will be used by MCC in understanding health education needs in "hot spot" areas.										
Task 4. REAL data collection will guide MCC population health program delivery and education through partnering with cultural CBOs in hot spot areas.										
Task 5. REAL data collection will help MCC connect PCP practices to local MCC cultural CBO partners. MCC to maintain documentation of training support including written training materials and training dates along with number of staff trained.										
Task 6. If patient is eligible for health home services, MCC Clinical Outreach Team will work with PCP practices on workflows for warm referrals to Health Homes.										
Task 7. The warm referral to Health Home Case management will leverage information from the RHIO, HEALTHeLINK.										
Task 8. The referral process will secure complete and signed PHI disclosure for referral to Health Home Case management.										
Task 9. Training dates will be recorded along with the number of primary care practice staff and trained in making linkages to health homes for care coordination. All trainings will be reported to the Practice Engagement team.										
Task 10. MCC Partner Database to list all CDSMP/Stanford Model CBO sites.										
Task 11. Community program sites listed by county and region are available through the NY State Health Data. Program training for the Stanford model is available through the New York State Quality and Technical Assistance Center (NYS _QTAC).										
Task 12. For ongoing care coordination, facilitate a referral process for warm referrals to CBOs (who have signed agreements with MCC										

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) to enroll patients in CDSMP/Stanford Model.										
Task 13. MCC will provide training on the referral process and written training materials on available CDSMP resources , program locations, how to explain the program to patients, and how to refer patients to the programs.										
Task 14. MCC will record all training dates and number of staff trained along with written training materials provided to the primary care practice teams. All trainings will be reported to the Practice Engagement team.										
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	5	10	15	27	52	92	200	300
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	5	10	15	25	75	150
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	1	2	4	8	12	20	45	70
Task 1. MCC will identify PCP sites and maintain a list of sites implementing the four main program components of MHP. The MHP initiatives will be used to meet PCMH 2014 level 3 Std 4 (care management of chronic conditions) and Std 6 (Evaluating quality improvement).										
Task 2. PCMH lead will work with sites to create a workflow that includes identification, tracking, and outreach for patients with a diagnosis of hypertension and who have not had a PCP visit within the last six months. PCMH lead will maintain a list of all PCP sites trained in workflow implementation.										
Task 3. Policies and workflows developed will ensure that patients are contacted to confirm appointments and instructed to bring in all their medication for review at their appointment.										
Task 4. Policies will be established to record BP measurement at each PCP visit as well as screen patients for cholesterol and tobacco										

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use according to the MHP.										
Task 5. The workflow will detail monitoring patients with vascular disease for Aspirin use. Patients at high risk for ASCVD using the risk calculator tool will be treated according to goal based on the established treatment guidelines.										
Task 6. A self management plan will be provided to each patient at the end of each office visit.										
Task 7. Training will be offered to PCP staff on warm transfers to MCC CBOs on customized self management support for lifestyle changes (CDSMP Programs), medication adherence, NYS Quitline, and other resources as needed.										
Task 8. Workflows will detail warm transfer to MCC CBO partners for ongoing MCC CBO support and documentation of referrals made.										
Task 9. Written training materials will also be provided: training to the clinical care coordination team on BP measurement, motivational interviewing strategies, and workflows for warm transfer of patients for ongoing community support.										
Task 10. Training will be provided to MCC partners on accepting a warm transfer from the primary care practices.										
Task 11. All trainings dates and locations will be recorded and a list of trainings dates and written materials provided will be reported to the Practice Engagement Team on an ongoing basis.										
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. Assess ability to contract with MCOs for coordination of services (hypertension screening, smoking cessation referral, cholesterol screening and other preventative services) related to CVD management.										

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Task 2. Elicit input from MCOs on elements of a multi-year plan to transition to VBP system; present proposed plan (including coordination of services for high-risk populations) to MCOs.										
Task 3. Explain to MCOs the goals for managing high-risk population through collaboration: a) educating providers on MHP components, b) support implementation of MHP to manage patients for Level 3 2014 PCMH accreditation, c) refer patients to MCC CBO partners.										
Task 4. Seek MCOs' revisions and approval of plan to coordinate services under this project. Catalog the main issues and data needs necessary for resolution as a part of the plan approval process.										
Task 5. Establish incentives based on utilization and quality metrics related to managing cardiovascular disease in the affected Medicaid population.										
Task 6. Use the VBP transition plan to guide agenda in monthly MCO meetings.										
Task 7. Obtain signed agreement with MCOs and list dates of signed agreements. Medicaid Managed care metrics and opportunities reported to MCC Board of Manager committees.										
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	5	10	15	27	52	92	200	300
Task 1. Design project goals, interventions, metrics, and reporting measures; work with PCMH coordinator to implement these interventions as a part of the QI standards (Standard 6) required for Level 3 PCMH certification.										
Task 2. Create a list of providers engaged in PCMH accreditation using the Million Hearts Quality Improvement Program.										
Task 3. Assess percentage of providers engaged using the Million Hearts/Cardiovascular disease management as a QI project for Level 3 PCMH certification.										
Task 4. Work with Clinical Outreach team and PCMH practice										

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engagement coordinator to implement MH interventions and record staff trainings. Provide MCC Partner database of community resources as a continued resource.										
Task 5. Establish quarterly touch points to PCP to communicate with providers on a) Performance measures related to the MHP, b) ongoing management as a QI program for Standard 6 Level 3 PCMH accreditation, and c) referral of patients to community resources.										
Task 6. Determine number of MCC PCP sites engaged in Million Hearts and conduct annual reviews to identify new PCP sites for ongoing support/outreach/training until 80 % of PCPs are engaged.										

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. Develop comprehensive MCC partner database for MCC partners included in the management of CVD. Partner database will categorize partners by provider type (including ambulatory care or community care partner) and demonstrate changes to the network list.										
Task 2. Collect appropriate clinical tools necessary for the different goals of the Million Hearts Program (MHP): blood pressure guidelines, cholesterol management guidelines, and the tools for smoking cessation.										
Task 3. Disseminate written evidence-based treatment protocols for managing CVD using the techniques and resources provided on the Million Hearts Campaign program website.										
Task 4. Define priority target population, and develop a framework for patient database to include risk stratified registries and blood pressure measurements.										

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Task 5. Identify pilot PCP sites to implement MHP.										
Task 6. Meet with each practice site on identified list.										
Task 7. List all PCP sites that plan on using Million Hearts registries and work on process flows at each PCP site to manage CVD population using Million Hearts criteria.										
Task 8. Develop process and identify vendor for patient registry/database development. Vendor to interface with data points available through the regional RHIO (HEALTHeLINK) to integrate information from disparate EHRs from primary care offices.										
Task 9. Pilot test patient database to integrate EHR data points from a variety of Primary Care offices relevant to risk stratification, blood pressure, and cardiovascular medications.										
Task 10. Track and monitor patient engagement at each PCP practice site and build quarterly performance metrics related to the four program areas in Million Hearts to verify continuous improvement.										
Task 11. Begin reporting on implementation of project requirements quarterly according to project milestone reporting requirements.										
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.	100	126	126	126	126	126	126	126	126	126
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	35	43	43	43	43	43	43	43	43	43
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	65	70	70	70	70	70	70	70	70	70
Task PPS uses alerts and secure messaging functionality.										
Task 1. Conduct gap analysis to determine which providers have										

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already completed PCMH/MU or other connectivity readiness assessment. Include the following questions: Is the practice/providers/patients currently connected to the HIE? If not, is an agreement in place? If so, what is the scope of the connectivity (% of providers; % of patients)? Does EHR meet connectivity requirements of RHIO/SHIN-NY? Name of EHR, version, and electronic functionalities in use										
Task 2. Develop strategy for low-cost data connectivity between ISPs (e.g., WNY R-AHEC) and local practice plans to determine minimum hardware and software requirements.										
Task 3. Gather results from readiness assessments already conducted.										
Task 4. Issue request for applications (RFA) or other action step for readiness assessment and transformation support services.										
Task 5. Select vendor or implement other structure for readiness assessment and transformation support services.										
Task 6. Identify funding model and/or PPS provider incentive model for EHR with the Finance Committee.										
Task 7. Connect PPS providers to MCC enterprise DSRIP solution.										
Task 8. Implement enterprise DSRIP solution and start data exchange.										
Task 9. Implement PPS providers in waves grouped by the partner's ability to connect and integrate into the solution; start with the most able to connect; add others as they establish their capabilities.										
Task 10. Systematically contact PPS providers to provide the recommended enterprise DSRIP solution.										
Task 11. Facilitate QE participation agreements with MCC providers.										
Task 12. Implement and deploy patient record look-up training.										
Task 13. Implement and deploy MCC DSRIP dashboard reporting capabilities. Provide EHR vendor documentation, screenshots, and/or samples of transactions to public health registries. Designate experts at each PCP site for ongoing support.										

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Task 14. Implement and deploy alerts. Provide EHR vendor documentation, screenshots, and/or evidence of use of alerts.										
Task 15. Implement and deploy secure Direct messaging. Provide EHR vendor documentation, screenshots, and/or evidence of use of secure Direct messaging.										
Task 16. Continuously add MCC providers when their EHR and data exchange capabilities reach the minimal level required to connect to the MCC EHR and data exchange/HIE.										
Task 17. Maintain list of all PPS safety net providers with secure Direct messaging capabilities who completed training. Report to Physician Performance Sub-Committee.										
Task 18. MCC providers who are not actively exchanging systems will be reviewed by the Physician Performance Sub-Committee. Corrective actions will be implemented for those members found noncompliant.										
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.	450	600	600	600	600	600	600	600	600	600
Task 1. Conduct Safety Net MU stage 2 CMS/PCMH level 3 readiness assessment: (a) identify site-specific IT/care management leadership, (b) determine current EHR PCMH/MU certification status, and (c) identify site-specific barriers and risks to implementing a MU/PCMH Level 3 certified EHR system.										
Task 2. Facilitate engagement with MU/PCMH-certified EHR vendors as needed.										
Task 3. Establish PCMH/MU project implementation plan based on primary care practice readiness and certification status.										
Task 4. Review PCMH implementation plan for approval by the										

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Clinical/Quality Committee.										
Task 5. Ensure practices have support through the PCMH implementation process either through a vendor or through MCC PCMH coordinators.										
Task 6. Establish a monthly review and measurement process of implementation progress and report to Clinical/Quality Committee.										
Task 7. Modify implementation plan as needed based on monthly review process.										
Task 8. Practices provide MU and PCMH Level 3 certification documentation to the PPS.										
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. Define IT requirements for initializing/maintaining/communicating risk stratification across settings, including means for electronic interfacing to the participating provider community and key data sharing.										
Task 2. MCC vendor solution will include communication channels to track targeted patients in the database for monitoring blood pressure, cholesterol, smoking status, and cardiovascular medications.										
Task 3. MCC vendor solution will implement and deploy population health management by leveraging data from the data exchange/HIE environments.										
Task 4. Select pilot test sites for Million Hearts implementation of patient engagement registries.										
Task 5. Review Million Hearts program goals and work with PCMH coordinator to get buy-in to implement as a QI program for PCMH accreditation.										
Task 6. Identify criteria required to develop registry and create patient										

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registries.										
Task 7. Work with identified practices on Million Hearts focused clinical criteria on monitoring registries at PCP offices for care coordination outreach (PCMH Standard 4 requirement) and verify engagement.										
Task 8. Report on patient engagement and engaged safety net practices according to project milestone reporting requirements.										
Task 9. Assess continuous improvement by monitoring clinical quality measures (PCMH Standard 6).										
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. Engage NYS Quitline to ensure that resources are available and referral information can be shared with primary care practice staff for referral of patients to community-based smoking cessation resources.										
Task 2. Develop written training materials, resources, list training dates.										
Task 3. Work with Quitline team to offer primary care practice staff trainings on available Quitline resources.										
Task 4. Work with Quitline team to develop training modules for practices (on available patient engagement resources, telephonic motivational coaching, web-based peer coaching, personalized text messaging, and screening for NRT eligibility).										
Task 5. Promote Opt to Quit™ opt-out policy at practices. Promote integration of Tobacco Use screening workflows (including EHR prompt within practice EHRs to automate completion of 5As of Tobacco control).										
Task 6. Use EHR to build automated referral processes to facilitate										

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coordination of care and transition through Quitline referrals.										
Task 7. Integrate tobacco cessation counseling in PCMH 2014 Level 3 accreditation workflow for managing CVD including assessment and monitoring of tobacco use (PCMH Std 3 includes recording comprehensive health assessment, using data in EB decision support).										
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. Request an American Heart Association (AHA) Spotlight Series Speaker offering CME/CE and grand rounds presentation on topics related to cardiovascular disease in a hospital setting in collaboration with partner PPS organizations (FLPPS and CPWNY).										
Task 2. Define the need to adhere to clinical algorithms in master services agreement (MSA) for all PCPs participating in Domain 3 projects.										
Task 3. Support MCC PCP partners who have signed MSA by educational detailing to make practices aware of the Million Hearts website resources (patient education web, video tools and printed materials, practice management tools, lifestyle management website resources).										
Task 4. Define protocols in EHR at participating PCPs to identify patients in the Million Hearts registry.										
Task 5. Conduct analysis to see if clinical protocols exist and determine if gaps are present.										
Task 6. Plan to close gaps in workflows and protocols to support patients in the Million Hearts registry at participating sites.										
Task 7. To close gaps, support MCC PCP partners by educational detailing for decision support tools and treatment algorithms to assess CVD including clinical treatment algorithms/guideline pocket cards for cholesterol, blood pressure, lifestyle										

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management, and obesity management.										
Task 8. Evaluate the need to offer CME to clinical teams for training related to the use of clinical treatment algorithms to manage blood pressure.										
Task 9. List all training dates and number of staff trained along with training materials provided.										
Task 10. Build MCC partner database to include CBOs with health, wellness, and prevention programs. MCC will document evidence of agreement to allow CBOs to accept warm referrals. Partner database available to all MCC PCP sites and updated on a quarterly basis as new partners are added.										
Task 11. Begin providing periodic reports of the clinical quality measures for CVD management to the Clinical/Quality Committee. Work with Practitioner Engagement Liaison to track adoption of protocols that are aligned with national guidelines.										
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. MCC PCMH project lead will identify and recruit a project champion at PCP site to assist with EHR integration to MCC HIE and RHIO for building a clinically interoperable system.										
Task 2. MCC PCMH project lead to assist with identifying practice champions at PCP sites to support MHP goals for PCMH Std 4 (care management support). Establish practice level workflows to identify patients in CVD registry, address and record patient goals. Create a list of participating PCP partner sites.										

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Task 3. Build training on BP and LDL management protocols to help identified PCP partners develop workflows and treatment protocols for care management. Use AHA-approved protocols and MHP clinical treatment algorithms. List all training dates for offered trainings.										
Task 4. Increase the adoption of standard clinical protocols and treatment plans available for CVD management through MHP.										
Task 5. Provide a list of care coordination resources in the community including community programs such as free or low-cost community wellness classes.										
Task 6. For ongoing care coordination, facilitate a referral process for warm referrals to CBOs (who have signed agreements with MCC) and partners (health home care managers where applicable, pharmacists, dietitians, and community health workers).										
Task 7. MCC to develop a PPS partner database for coordination resources available outside the practice setting (e.g., CDSMP/Stanford model, tobacco cessation classes, Baby and Me Tobacco Free, nutrition counseling, community cooking classes).										
Task 8. MCC PCMH project lead to document workflows to increase referrals to resources such as medication therapy management, dietician referrals, community health workers (and health homes if eligibility requirements are met).										
Task 9. MCC partner database will be disseminated to practice champions. MCC partner database will contain regional categories of partners, provider type and primary contacts for these referral services. Database will be updated as new partners are engaged										
Task 10. MCC Clinical Outreach team will support the PCMH project lead in monitoring and tracking the number and location of primary care practices using the team-based care model for managing cardiovascular disease.										
Task 11. MCC will work with the PCMH project lead to ensure that practices are documenting self management goals in medical record (diet, exercise, medication management, nutrition, etc.).										

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Millennium Collaborative Care (PPS ID:48)

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. MCC will collaborate with the RHIO, HEALTHeLINK, to establish a clinically interoperable system for data sharing with participating providers.										
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.	450	600	600	600	600	600	600	600	600	600
Task 1. Work on sustainable strategies with the Health Plans for PCP practice sites to offer blood pressure checks to patients without a copayment or appointment.										
Task 2. Train care coordination team and other non-clinical practice team members in proper blood pressure measurement technique so patients can obtain drop in blood pressure readings.										
Task 3. Work with each participating PCP site to develop EHR alerts to the site if blood pressure check is overdue.										
Task 4. At each practice, update patient registry with blood pressure check dates recorded. Update patient roster at regular intervals to monitor patients at different practice sites who have received follow up blood pressure checks.										
Task 5. Ask PCP sites to run quarterly reports for patients who have received follow up blood pressure checks										
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. Practice-wide policy instituted to ensure that practice staff are trained in BP measurement. MCC Clinical Outreach team to build workflow to recheck BP reading and establish future interventions/self management goals if blood pressure above goal.										
Task 2. To track accurate measurement of blood pressure by staff, workflows will be established within the practice to alert 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
members about patterns of high blood pressure taken by support team.										
Task 3. Offer CME to coordination team members for blood pressure measurement technique, AHA guidelines for BP management, and develop training protocol for BP measurement. List of training dates and staff in attendance for all trainings.										
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. Create process to monitor in PPS patient database, targeted registry for patients at PCP offices with elevated BP (SBP >140 mmHg and DBP >90 mmHg) but no diagnosis of hypertension (indicated in the medical record).										
Task 2. Work with PCP champion identified at each practice site on workflows for team to identify, target, and schedule appointment for patients with repeated elevated BP (SBP >140 mmHg and DBP >90 mmHg) but no diagnosis of hypertension is indicated in the medical record.										
Task 3. Offer training to staff to ensure effective patient identification and visit scheduling for documentation of hypertension visit. List all training dates and number of staff trained along with written training materials provided.										
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.										

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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. MCC Clinical Outreach team working with the PCP should ensure that a medical management policy is in place for primary care practice partners.										
Task 2. Get list of PCP offices with signed medical management policy.										
Task 3. Policy should include adoption of workflows on medication adherence/reminders, potential side effects of medication, prescription of medications included in patient covered formulary, fixed dose combination pills or once daily regimen (if possible to promote medication adherence), refill strategy to manage medication refills as necessary.										
Task 4. Run a query using MCC HIE solution for Rx claims data for each PCP site to identify list of PCP offices instituting medical management policy.										
Task 5. Obtain a list of participating PCPs who have not prescribed once-daily regimens or fixed combination therapy for MCC recipients.										
Task 6. Set up appointments at each PCP site to review results on an annual basis. Record all dates for medication review and report annually to the Clinical/Quality Committee.										
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. MCC Clinical Outreach team will help develop web-based training modules on PCMH Stds for PCP partners (non-safety net and safety net PCP). Training module includes documenting patient self-engagement goals and periodic self audit.										
Task 2. Work with MCC Clinical Director to identify PCMH practices seeking PCMH accreditation and interested in adopting Million Hearts as the Quality Improvement program.										
Task 3. Create a list of practices using the Million Hearts program 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
conduct a needs assessment to determine gaps in each practice for processes, clinical tools and workflows.										
Task 4. Use findings from Needs Assessment to support MCC PCMH lead in implementation of MHP interventions for PCMH Std 4 - Care Management measures. (PCMH Measure 4 Element B includes practice team documenting patient self-management goals in the EHR.)										
Task 5. Monitor PCMH accreditation process and workflows to incorporate MH protocols and processes at determined PCP sites.										
Task 6. Use EHR to establish registries of patients eligible for the MH interventions and monitor documentation required (self-management goals in the medical record) to meet requirements for Patient Engagement Speed.										
Task 7. A list of resources to support the patient's self-management goals should be offered and noted in the medical record. May include referrals for CDSMP/Stanford Model, tobacco cessation resources, nutrition counseling, and community cooking classes.										
Task 8. MCC Clinical Outreach team will periodically facilitate training on motivational interviewing strategies to improve patient self-management.										
Task 9. A list of training dates and staff trained should be maintained by the PPS and reported periodically to the practice engagement team.										
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.										

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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. MCC will document evidence of agreement with CBOs. Partner database list will be available to MCC PCP sites.										
Task 2. If patient is eligible for health home, MCC clinical outreach team will work with PCP practices on a workflow or warm referrals to health homes.										
Task 3. Maintain a list of MCC PCP sites who have established a process for warm referrals.										
Task 4. Develop process to track referrals made to community-based programs and health homes by MCC PCP practices.										
Task 5. Practices will be provided with an MCC partner database for direct referral for CBO services (for patients who may not be eligible for health home interventions).										
Task 6. Train practices on making warm referrals to health homes and CBOs. Maintain list of training dates for each PCP site.										
Task 7. MCC clinical outreach team will provide written training materials on making warm referrals.										
Task 8. Evaluate and track warm referrals made by each MCC PCP practice to health homes and/or community based organizations every quarter. Review count of referrals made to CBOs to facilitate feedback. Report to Clinical/Quality Committee on count of warm referrals made to CBOs and health homes by PCP practice sites.										
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. Identify which MCOs in the MCC network cover the majority of										

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the attributed members and work with the benefit managers of these plans to promote coverage for validated Self Monitoring of Blood Pressure (SMBP) monitors.										
Task 2. MCC Clinical Outreach team will identify and work with academic detailers to support primary care practice team on securing and using SMBP monitors.										
Task 3. MCC Clinical outreach team to facilitate trainings for PCP team to teach cuff selection, patient positioning, measurement without talking, and accurate blood pressure observation.										
Task 4. Trainings for the practice team on ways to support self monitoring including educating patients about the importance of self monitoring for BP, training patient on using the device, and providing BP logs to the care team.										
Task 5. Development of workflows and policies to support patients on self monitoring of BP at home: during follow up visits, PCP team will review patient SMBP readings, request medication fills, provide summaries of clinic visits.										
Task 6. MCC clinical outreach team will support staff on referral mechanisms for ongoing patient outreach support and follow up if blood pressure results above goal through periodic recording of self-recorded BP.										
Task 7. Support for the PCP team to include resources for patient referrals to community classes for lifestyle management (CDSMP/Stanford model programs, dietician referrals, Quitline resources, and medication therapy education).										
Task 8. PCP team trainings on protocols to review patient support tools (such as written information or videos on how to self monitor blood pressure, a contact for patients at the practice to call with questions).										
Task 9. Clinical outreach team to support PCP practice staff through training for protocols during follow up visits including reviewing patient SMBP readings, requesting medication fills, providing summaries of clinic visits.										
Task 10. List training dates and number of MCC PCP partners attending training sessions. Record all additional resources provided to trainees including a list of community based classes										

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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 through the MCC Partner Database.										
Task 11. Work with MCC vendor solution to build alerts into patient registry for patients diagnosed with high blood pressure but no documentation of recent PCP visit in rolling six-month timeframe.										
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. MCC clinical outreach team schedule training sessions for primary care practice team on workflows to outreach to roster of identified patients who need to schedule a follow up visit.										
Task 2. MCC Clinical outreach team help develop workflows for (a) reminder calls for follow up visit and (b) a system to connect with external MCC care coordination team (community health workers) to engage patients if practice is unsuccessful in telephonic outreach.										
Task 3. MCC will document list of practices trained on scheduling follow up visit.										
Task 4. Documentation of patients engaged through a follow up visit to manage their hypertension will be recorded in the vendor system.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task 1. MCC will collaborate with Health Systems Centers for a Tobacco Free WNY (Roswell Park) to assist in creation and adoption of policies and programs to help patients quit using tobacco products.										
Task 2. Maintain a list of MCC PCP sites participating in the Million Hearts program to target for ongoing training on warm referrals.										
Task 3. Facilitate training sessions for MCC primary care practice partners on available NYS Quitline cessation resources.										

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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. Implement training at participating MCC PCP sites (on NYS Quitline and cessation services offered through the program). Maintain a list primary care practice sites trained in making warm referrals.										
Task 5. MCC will monitor a list of PCP sites demonstrating evidence of warm referrals to the NYS Quitline.										
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. MCC to implement collection of REAL (Race Ethnicity and Language) data via the EHR vendor systems of MCC PCP partners. REAL data collection is critical for Population Health in 2014 Level 3 PCMH Std and MU Stage 2 core requirement.										
Task 2. Demographic information and REAL data are collected as structured data to be imported into the MCC Population Health management system to target high risk populations.										
Task 3. REAL data collected will be used by MCC in understanding health education needs in "hot spot" areas.										
Task 4. REAL data collection will guide MCC population health program delivery and education through partnering with cultural CBOs in hot spot areas.										
Task 5. REAL data collection will help MCC connect PCP practices to local MCC cultural CBO partners. MCC to maintain documentation of training support including written training materials and training dates along with number of staff trained.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task 6. If patient is eligible for health home services, MCC Clinical Outreach Team will work with PCP practices on workflows for warm referrals to Health Homes.										
Task 7. The warm referral to Health Home Case management will leverage information from the RHIO, HEALTHeLINK.										
Task 8. The referral process will secure complete and signed PHI disclosure for referral to Health Home Case management.										
Task 9. Training dates will be recorded along with the number of primary care practice staff and trained in making linkages to health homes for care coordination. All trainings will be reported to the Practice Engagement team.										
Task 10. MCC Partner Database to list all CDSMP/Stanford Model CBO sites.										
Task 11. Community program sites listed by county and region are available through the NY State Health Data. Program training for the Stanford model is available through the New York State Quality and Technical Assistance Center (NYS _QTAC).										
Task 12. For ongoing care coordination, facilitate a referral process for warm referrals to CBOs (who have signed agreements with MCC) to enroll patients in CDSMP/Stanford Model.										
Task 13. MCC will provide training on the referral process and written training materials on available CDSMP resources , program locations, how to explain the program to patients, and how to refer patients to the programs.										
Task 14. MCC will record all training dates and number of staff trained along with written training materials provided to the primary care practice teams. All trainings will be reported to the Practice Engagement team.										
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.	450	600	600	600	600	600	600	600	600	600
Task Provider can demonstrate implementation of policies and	300	415	415	415	415	415	415	415	415	415

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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
procedures which reflect principles and initiatives of Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	100	165	165	165	165	165	165	165	165	165
Task 1. MCC will identify PCP sites and maintain a list of sites implementing the four main program components of MHP. The MHP initiatives will be used to meet PCMH 2014 level 3 Std 4 (care management of chronic conditions) and Std 6 (Evaluating quality improvement).										
Task 2. PCMH lead will work with sites to create a workflow that includes identification, tracking, and outreach for patients with a diagnosis of hypertension and who have not had a PCP visit within the last six months. PCMH lead will maintain a list of all PCP sites trained in workflow implementation.										
Task 3. Policies and workflows developed will ensure that patients are contacted to confirm appointments and instructed to bring in all their medication for review at their appointment.										
Task 4. Policies will be established to record BP measurement at each PCP visit as well as screen patients for cholesterol and tobacco use according to the MHP.										
Task 5. The workflow will detail monitoring patients with vascular disease for Aspirin use. Patients at high risk for ASCVD using the risk calculator tool will be treated according to goal based on the established treatment guidelines.										
Task 6. A self management plan will be provided to each patient at the end of each office visit.										
Task 7. Training will be offered to PCP staff on warm transfers to MCC CBOs on customized self management support for lifestyle changes (CDSMP Programs), medication adherence, NYS Quitline, and other resources as needed.										
Task 8. Workflows will detail warm transfer to MCC CBO partners for ongoing MCC CBO support and documentation of referrals made.										
Task 9. Written training materials will also be provided: training to the										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
clinical care coordination team on BP measurement, motivational interviewing strategies, and workflows for warm transfer of patients for ongoing community support.										
Task 10. Training will be provided to MCC partners on accepting a warm transfer from the primary care practices.										
Task 11. All trainings dates and locations will be recorded and a list of trainings dates and written materials provided will be reported to the Practice Engagement Team on an ongoing basis.										
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. Assess ability to contract with MCOs for coordination of services (hypertension screening, smoking cessation referral, cholesterol screening and other preventative services) related to CVD management.										
Task 2. Elicit input from MCOs on elements of a multi-year plan to transition to VBP system; present proposed plan (including coordination of services for high-risk populations) to MCOs.										
Task 3. Explain to MCOs the goals for managing high-risk population through collaboration: a) educating providers on MHP components, b) support implementation of MHP to manage patients for Level 3 2014 PCMH accreditation, c) refer patients to MCC CBO partners.										
Task 4. Seek MCOs' revisions and approval of plan to coordinate services under this project. Catalog the main issues and data needs necessary for resolution as a part of the plan approval process.										
Task 5. Establish incentives based on utilization and quality metrics related to managing cardiovascular disease in the affected Medicaid population.										
Task 6. Use the VBP transition plan to guide agenda in monthly MCO										

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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
meetings.										
Task 7. Obtain signed agreement with MCOs and list dates of signed agreements. Medicaid Managed care metrics and opportunities reported to MCC Board of Manager committees.										
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.	450	600	600	600	600	600	600	600	600	600
Task 1. Design project goals, interventions, metrics, and reporting measures; work with PCMH coordinator to implement these interventions as a part of the QI standards (Standard 6) required for Level 3 PCMH certification.										
Task 2. Create a list of providers engaged in PCMH accreditation using the Million Hearts Quality Improvement Program.										
Task 3. Assess percentage of providers engaged using the Million Hearts/Cardiovascular disease management as a QI project for Level 3 PCMH certification.										
Task 4. Work with Clinical Outreach team and PCMH practice engagement coordinator to implement MH interventions and record staff trainings. Provide MCC Partner database of community resources as a continued resource.										
Task 5. Establish quarterly touch points to PCP to communicate with providers on a) Performance measures related to the MHP, b) ongoing management as a QI program for Standard 6 Level 3 PCMH accreditation, and c) referral of patients to community resources.										
Task 6. Determine number of MCC PCP sites engaged in Million Hearts and conduct annual reviews to identify new PCP sites for ongoing support/outreach/training until 80 % of PCPs are engaged.										

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Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	
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.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	

Milestone Review Status

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

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Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	
Milestone #12	Pass & Ongoing	
Milestone #13	Pass & Ongoing	
Milestone #14	Pass & Ongoing	
Milestone #15	Pass & Ongoing	
Milestone #16	Pass & Ongoing	
Milestone #17	Pass & Ongoing	
Milestone #18	Pass & Ongoing	
Milestone #19	Pass & Ongoing	
Milestone #20	Pass & Ongoing	

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 3.f.i – Increase support programs for maternal & child health (including high risk pregnancies) (Example: Nurse-Family Partnership)

IPQR Module 3.f.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.

Patient hand-off not always consistent or effective between varying levels of care. Establish clearly defined care transition with training available. Ensure information transfer includes the timely exchange of patient data among all stakeholders.

The lack of centralized information on the status of clients could lead to service duplication or gaps. The MCC IT program will provide for the use of standardized care coordination software to be utilized across DSRIP projects. Selection criteria for this software include ease of use (so as to minimize the amount of time it takes to train a cross-section of workers) and interoperability (improving its applicability to practices). Project timeliness will require a short-term electronic solution that will be developed to track and report on the status of clients. An interim solution is essential since it will pave the way for the use of standard workflows that will be a crucial part of utilizing the software. Participation in the Maternal and Child Health (MCH) project by community-based organizations and other entities will be predicated on their willingness to utilize the prescribed software.

Failure to consistently deploy evidence based techniques associated with MCH (e.g., Healthy Families) will lead to poor outcomes that fall short of targeted metrics. Project team will reach out to regional MCH experts to seek their input on the use of a set of evidence-based techniques that will guide operation of the project both administratively and in the field. Project team members will receive training on evidence-based standards initially and throughout the duration of the project.

Insufficient pool of community health workers (CHWs) to support MCH programs due to large geographical and culturally diverse regions of WNY. Implement strategies identified in MCC's Workforce Strategy Roadmap to recruit CHWs from urban and rural communities throughout WNY that comprise diverse racial and ethnic compositions. Tap the expertise of existing agencies that have a proven track record for training and retaining CHWs in target key geographical areas, including the ability to host training at locations throughout WNY.

State funding for current programs proposed will be pooled in "maternal and infant health block grants" in 2015 NYS budget. Continue to lobby the state to maintain current funding methodologies for MCH programs.

Failure to provide third-party payer reimbursement for MCH CHW services will not sustain the program after the waiver period. Rank value-based payments (VBP) for MCH project as a priority in MCC's VBP Transition plan. As part of this plan, work with local payers to create reimbursement methodologies to support the outreach services provided by CHWs.

MCC and Community Partners of WNY (led by Catholic Medical Partners) will both implement project 3.f.i., utilizing different models (CHW vs. nurse/family partnership). Cooperation in the form of mutual referrals will be necessary to provide comprehensive support across the whole region and ensure patients are matched up with the most appropriate services. If providers are reluctant to refer patients out of network, the effectiveness

of the programs could be reduced. To create a seamless transition for patients, MCC will work with our partnering PPSs to standardize processes, tracking mechanisms, and reporting tools while maintaining common messaging to educate/communicate with patients. MCC will work collaboratively with WNY PPSs to expand the scope and expertise of the Regional Perinatal Center and the Regional Perinatal Outreach grant.

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY2,Q4	1,000

Patients Engaged to Date in Current DY	DY1,Q3 Patient Update	% of Semi-Annual Commitment To-Date	Semi-Annual Variance of Projected to Actual	% of Total Actively Engaged Patients To-Date
295	343	68.60%	157	34.30%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (500)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
ethelen	Baseline or Performance Documentation	48_PMDL5015_1_3_20160202185902_3fi_PE_registry_DY1Q3.xlsx	Patient engagement registry showing 48 patients engaged in Q3	02/02/2016 06:59 PM

Narrative Text :

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

patients previously reported in DY1Q2: 295. new patients engaged in DY1Q3: 48. total cumulative patients engaged: 343

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.	Model 1	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has developed a project plan that includes a timeline for implementation of an evidence-based home visiting model, such as Nurse-Family Partnership visitation model, for this population.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #2 Develop a referral system for early identification of women who are or may be at high-risk.	Model 1	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has developed a referral system for early identification of women who are or may be at high-risk.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #3 Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.	Model 1	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 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		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task		Project		On Hold	04/01/2015	03/31/2020	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
PPS evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Perinatal Care Metrics.										
Task Service and quality outcome measures are reported to all stakeholders.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #4 Use EHRs or other IT platforms to track all patients engaged in this project.	Model 1	Project	N/A	On Hold	04/01/2015	03/31/2020	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has identified and engaged with a regional medical center to address the care of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center). Assessment of the volume of high-risk pregnancies to be obtained through the CNA.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #6 Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has assembled a team of experts, including the number and type of experts and specialists and roles in the multidisciplinary team, to address the management of care of high-risk mothers and infants.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has established MOUs or joint operating agreements with substantive multidisciplinary team responsible for co-managing care of high-risk mothers and infants.		Project		On Hold	04/01/2015	03/31/2020	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #7 Develop service MOUs between multidisciplinary team and OB/GYN providers.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has identified and established MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #8 Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has developed/adopted uniform clinical protocols guidelines based upon evidence-based standards agreed to by all partners.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has established best practice guidelines, policies and procedures, and plans for dissemination and training for interdisciplinary team on best practices.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Training has been completed.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #9 Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.		Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR or other IT platforms, meets connectivity to RHIO's		Provider	Safety Net Clinic	On Hold	04/01/2015	03/31/2020	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	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
HIE and SHIN-NY requirements.										
Task PPS uses alerts and secure messaging functionality.		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #10 Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task EHR or other IT platforms meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).		Project		On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.		Provider	Safety Net Practitioner - Primary Care Provider (PCP)	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #11 Use EHRs or other IT platforms to track all patients engaged in this project.	Model 2	Project	N/A	On Hold	04/01/2015	03/31/2020	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	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #12 Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.	Model 3	Project	N/A	In Progress	06/18/2015	03/31/2017	06/18/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS developed a work plan to use NYSDOH CHW training program and ensure CHW-trained members are integrated into the multidisciplinary team. PPS has obtained DOH funding for CHW training.		Project		In Progress	06/18/2015	03/31/2017	06/18/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Select vendor(s) via RFQ/RFP process.		Project		In Progress	06/18/2015	10/30/2015	06/18/2015	03/15/2016	03/31/2016	DY1 Q4
Task 2. Identify work team participants.		Project		Completed	08/25/2015	11/30/2015	08/25/2015	11/30/2015	12/31/2015	DY1 Q3
Task 3. Design CHW model program.		Project		In Progress	08/25/2015	01/18/2016	10/01/2015	01/18/2016	03/31/2016	DY1 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 4. Define CHW role within the multidisciplinary team.		Project		In Progress	08/25/2015	01/18/2016	08/25/2015	01/18/2016	03/31/2016	DY1 Q4
Task 5. Define training needs for each role. Coordinate with the Workforce Development Work Group, as appropriate.		Project		In Progress	08/25/2015	03/31/2016	08/25/2015	03/31/2016	03/31/2016	DY1 Q4
Task 6. Work in partnership with Cultural Competency/Health Literacy workstream to address cultural and linguistic needs.		Project		In Progress	08/25/2015	06/01/2016	08/25/2015	06/01/2016	06/30/2016	DY2 Q1
Task 7. Schedule/conduct onboarding training.		Project		In Progress	01/01/2016	06/01/2016	11/01/2015	06/01/2016	06/30/2016	DY2 Q1
Task 8. Assure training plan is in place for ongoing needs.		Project		Not Started	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 9. Define ongoing education requirements. Coordinate with the Workforce Development Work Group, as appropriate.		Project		Not Started	01/01/2016	10/28/2016	01/01/2016	10/28/2016	12/31/2016	DY2 Q3
Task 10. Assure funding for training in place.		Project		Not Started	06/01/2016	01/10/2017	06/01/2016	01/10/2017	03/31/2017	DY2 Q4
Task 11. Complete work plan document.		Project		In Progress	08/25/2015	03/31/2017	08/25/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.	Model 3	Project	N/A	In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has named assigned CHW Coordinator(s) or timeline for hiring CHW Coordinator(s).		Project		In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Identify workgroup team.		Project		Completed	09/24/2015	11/30/2015	09/24/2015	11/30/2015	12/31/2015	DY1 Q3
Task 2. Work in partnership with Cultural Competency/Health Literacy workstream to address cultural and linguistic needs.		Project		In Progress	09/24/2015	01/10/2017	09/24/2015	01/10/2017	03/31/2017	DY2 Q4
Task 3. Develop job description for CHW coordinator (supervisory).		Project		In Progress	09/24/2015	01/18/2016	09/24/2015	01/18/2016	03/31/2016	DY1 Q4
Task		Project		In Progress	09/24/2015	01/18/2016	09/24/2015	01/18/2016	03/31/2016	DY1 Q4

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4. Define staffing model utilizing DOH standards (1 supervisor to 4-6 CHWs).										
Task 5. Utilize data, CNA, and patient input to determine number of teams needed.		Project		In Progress	09/24/2015	09/15/2016	09/24/2015	09/15/2016	09/30/2016	DY2 Q2
Task 6. Develop employee evaluation process.		Project		Not Started	01/05/2016	05/02/2016	01/05/2016	05/02/2016	06/30/2016	DY2 Q1
Task 7. Employ qualified candidates.		Project		In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 8. Define training needs for role.		Project		In Progress	09/24/2015	03/30/2016	09/24/2015	03/30/2016	03/31/2016	DY1 Q4
Task 9. Schedule/conduct onboarding training.		Project		In Progress	03/30/2016	06/01/2016	11/01/2015	06/01/2016	06/30/2016	DY2 Q1
Task 10. Assure training plan is in place for ongoing needs.		Project		Not Started	07/05/2016	01/10/2017	07/05/2016	01/10/2017	03/31/2017	DY2 Q4
Task 11. Evaluate effectiveness and adjust as needed.		Project		Not Started	06/01/2016	01/10/2017	06/01/2016	01/10/2017	03/31/2017	DY2 Q4
Task 12. Complete staffing roster.		Project		In Progress	09/24/2015	03/30/2017	09/24/2015	03/30/2017	03/31/2017	DY2 Q4
Milestone #14 Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.	Model 3	Project	N/A	In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed a CHW workforce strategy and attendant qualifications of CHW(s) who meet the following criteria: 1) Indigenous community resident of the targeted area; 2) Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms; 3) Bilingual skills, depending on the community and families being served; 4) Knowledge of the community, community organizations, and community leaders; 5)Ability to work flexible hours, including evening and weekend hours.		Project		In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 1. Design workplan for deployment of CHW (workforce strategy).		Project		In Progress	09/24/2015	01/18/2016	09/24/2015	01/18/2016	03/31/2016	DY1 Q4
Task 2. Work in partnership with Cultural Competency/Health Literacy workstream to address cultural and linguistic needs.		Project		In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Develop job description.		Project		In Progress	09/24/2015	03/15/2016	09/24/2015	03/15/2016	03/31/2016	DY1 Q4
Task 4. Develop employee evaluation process.		Project		In Progress	09/24/2015	05/02/2016	09/24/2015	05/02/2016	06/30/2016	DY2 Q1
Task 5. Employ qualified candidates.		Project		In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 6. Schedule/conduct onboarding training.		Project		Not Started	03/30/2016	06/01/2016	03/30/2016	06/01/2016	06/30/2016	DY2 Q1
Task 7. Assure training plan is in place for ongoing needs.		Project		In Progress	09/24/2015	01/10/2017	09/24/2015	01/10/2017	03/31/2017	DY2 Q4
Milestone #15 Establish protocols for deployment of CHW.	Model 3	Project	N/A	In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established timelines to complete protocols (policies and procedures) for CHW program, including methods for new and ongoing training for CHWs.		Project		In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed plans to develop operational program components of CHW.		Project		In Progress	09/24/2015	03/31/2017	09/24/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Create list of needed policies/protocols with completion timeline.		Project		In Progress	09/25/2015	03/31/2016	09/25/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Develop policies and protocols.		Project		In Progress	10/01/2015	02/10/2016	10/01/2015	02/10/2016	03/31/2016	DY1 Q4
Task 3. Approval process.		Project		In Progress	11/02/2015	03/10/2016	11/02/2015	03/10/2016	03/31/2016	DY1 Q4
Task 4. Coordinate with the Workforce Development Work Group as appropriate to determine training needs.		Project		In Progress	09/25/2015	03/30/2016	09/25/2015	03/30/2016	03/31/2016	DY1 Q4
Task 5. Schedule/conduct training.		Project		Not Started	03/30/2016	06/01/2016	03/30/2016	06/01/2016	06/30/2016	DY2 Q1

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 6. Assure training plan is in place for ongoing needs.		Project		In Progress	09/24/2015	01/10/2017	09/24/2015	01/10/2017	03/31/2017	DY2 Q4
Task 7. Implement training for CHW.		Project		In Progress	09/24/2015	01/10/2017	09/24/2015	01/10/2017	03/31/2017	DY2 Q4
Task 8. Utilize planning team to develop workplan.		Project		In Progress	09/25/2015	03/01/2016	09/25/2015	03/01/2016	03/31/2016	DY1 Q4
Task 9. Work in partnership with 4.d.i. (Reduce Premature Births) and care management (ability to re-enforce applicable education).		Project		In Progress	09/25/2015	03/01/2016	09/25/2015	03/01/2016	03/31/2016	DY1 Q4
Task 10. Implement training (work in partnership with Cultural Competency/Health Literacy workstream to ensure training addresses cultural and linguistic needs).		Project		In Progress	03/01/2016	06/01/2016	10/01/2015	06/01/2016	06/30/2016	DY2 Q1
Task 11. Operationalize plan.		Project		Not Started	06/01/2016	09/05/2016	06/01/2016	09/05/2016	09/30/2016	DY2 Q2
Task 12. Deploy workers.		Project		In Progress	06/01/2016	09/05/2016	10/01/2015	09/05/2016	09/30/2016	DY2 Q2
Task 13. Develop QA process.		Project		In Progress	09/25/2015	06/15/2016	09/25/2015	06/15/2016	06/30/2016	DY2 Q1
Task 14. Implement QA process.		Project		Not Started	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task 15. Update workplan document (deployment outlined).		Project		Not Started	01/05/2017	03/31/2017	01/05/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Coordinate with the Medicaid Managed Care organizations serving the target population.	Model 3	Project	N/A	In Progress	08/25/2015	03/31/2017	08/25/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established agreements with MCOs demonstrating coordination regarding CHW program, or attestation of intent to establish coverage agreements, as well as progress to date.		Project		In Progress	08/25/2015	03/31/2017	08/25/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Coordinate Medicaid MCO outreach with project 2.a.i. (Integrated Delivery System) and the Value-Based Payment (VBP) Sub-Committee to coordinate and prioritize efforts across the projects.		Project		In Progress	08/25/2015	03/31/2017	08/25/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	11/01/2015	03/31/2017	11/01/2015	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
2. Coordinate discussions with partnering PPSs as appropriate.										
Task 3. Present project and objectives to top four Medicaid MCOs serving WNY (Independent Health, Fidelis, Blue Cross Blue Shield, YourCare) within the monthly schedules and priorities created in 2.a.i. (coordinated effort with higher level leadership coordination).		Project		In Progress	09/25/2015	03/15/2016	09/25/2015	03/15/2016	03/31/2016	DY1 Q4
Task 4. Engage Medicaid MCOs in discussion for coverage agreements within the monthly schedules and priorities created in 2.a.i. (coordinated effort with higher level leadership coordination).		Project		Not Started	03/15/2016	03/31/2017	03/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task 5. Continue dialogue to meet objectives including the metrics and outcomes to be evaluated.		Project		Not Started	03/15/2016	03/31/2017	03/15/2016	03/31/2017	03/31/2017	DY2 Q4
Task 6. Complete coverage agreements.		Project		Not Started	03/15/2016	03/31/2017	03/15/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #17 Use EHRs or other IT platforms to track all patients engaged in this project.	Model 3	Project	N/A	In Progress	09/25/2015	03/31/2017	09/25/2015	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	09/25/2015	03/31/2017	09/25/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Define metrics.		Project		In Progress	09/25/2015	03/30/2016	09/25/2015	03/30/2016	03/31/2016	DY1 Q4
Task 2. Work in partnership with project 2.a.i. (Integrated Delivery System).		Project		In Progress	09/25/2015	03/31/2017	09/25/2015	03/31/2017	03/31/2017	DY2 Q4
Task 3. Determine data elements required.		Project		In Progress	09/25/2015	04/29/2016	09/25/2015	04/29/2016	06/30/2016	DY2 Q1
Task 4. Complete gap analysis (partner/CBO capabilities for EHR and data exchange).		Project		Not Started	01/20/2016	06/30/2016	01/20/2016	06/30/2016	06/30/2016	DY2 Q1
Task 5. Determine strategy.		Project		Not Started	02/01/2016	06/30/2016	02/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task 6. Design training requirements.		Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4

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Project Requirements (Milestone/Task Name)	Project Model Name	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 7. Identify equipment needs.		Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 8. Obtain and deploy equipment.		Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 9. Schedule/conduct training.		Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 10. Develop technical support process.		Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4
Task 11. Design dashboard strategy for monitoring and QA.		Project		Not Started	06/30/2016	03/31/2017	06/30/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.										
Task PPS has developed a project plan that includes a timeline for implementation of an evidence-based home visiting model, such as Nurse-Family Partnership visitation model, for this population.										
Milestone #2 Develop a referral system for early identification of women who are or may be at high-risk.										
Task PPS has developed a referral system for early identification of women who are or may be at high-risk.										
Milestone #3 Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
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.										

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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 evaluates and creates action plans based on key quality metrics, to include applicable metrics listed in Attachment J Domain 3 Perinatal Care Metrics.										
Task Service and quality outcome measures are reported to all stakeholders.										
Milestone #4 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.										
Milestone #5 Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).										
Task PPS has identified and engaged with a regional medical center to address the care of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center). Assessment of the volume of high-risk pregnancies to be obtained through the CNA.										
Milestone #6 Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.										
Task PPS has assembled a team of experts, including the number and type of experts and specialists and roles in the multidisciplinary team, to address the management of care of high-risk mothers and infants.										
Task PPS has established MOUs or joint operating agreements with substantive multidisciplinary team responsible for co-managing care of high-risk mothers and infants.										
Milestone #7 Develop service MOUs between multidisciplinary team and OB/GYN providers.										
Task PPS has identified and established MOUs or joint operating agreements between multidisciplinary team and OB/GYN 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
Milestone #8 Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.										
Task PPS has developed/adopted uniform clinical protocols guidelines based upon evidence-based standards agreed to by all partners.										
Task PPS has established best practice guidelines, policies and procedures, and plans for dissemination and training for interdisciplinary team on best practices.										
Task Training has been completed.										
Milestone #9 Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task PPS uses alerts and secure messaging functionality.										
Milestone #10 Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR or other IT platforms meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Milestone #11 Use EHRs or other IT platforms to track all patients engaged in this 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
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Milestone #12 Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.										
Task PPS developed a work plan to use NYSDOH CHW training program and ensure CHW-trained members are integrated into the multidisciplinary team. PPS has obtained DOH funding for CHW training.										
Task 1. Select vendor(s) via RFQ/RFP process.										
Task 2. Identify work team participants.										
Task 3. Design CHW model program.										
Task 4. Define CHW role within the multidisciplinary team.										
Task 5. Define training needs for each role. Coordinate with the Workforce Development Work Group, as appropriate.										
Task 6. Work in partnership with Cultural Competency/Health Literacy workstream to address cultural and linguistic needs.										
Task 7. Schedule/conduct onboarding training.										
Task 8. Assure training plan is in place for ongoing needs.										
Task 9. Define ongoing education requirements. Coordinate with the Workforce Development Work Group, as appropriate.										
Task 10. Assure funding for training in place.										
Task 11. Complete work plan document.										
Milestone #13 Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.										
Task PPS has named assigned CHW Coordinator(s) or timeline for										

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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
hiring CHW Coordinator(s).										
Task 1. Identify workgroup team.										
Task 2. Work in partnership with Cultural Competency/Health Literacy workstream to address cultural and linguistic needs.										
Task 3. Develop job description for CHW coordinator (supervisory).										
Task 4. Define staffing model utilizing DOH standards (1 supervisor to 4-6 CHWs).										
Task 5. Utilize data, CNA, and patient input to determine number of teams needed.										
Task 6. Develop employee evaluation process.										
Task 7. Employ qualified candidates.										
Task 8. Define training needs for role.										
Task 9. Schedule/conduct onboarding training.										
Task 10. Assure training plan is in place for ongoing needs.										
Task 11. Evaluate effectiveness and adjust as needed.										
Task 12. Complete staffing roster.										
Milestone #14 Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.										
Task PPS has developed a CHW workforce strategy and attendant qualifications of CHW(s) who meet the following criteria: 1) Indigenous community resident of the targeted area; 2) Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms; 3) Bilingual skills, depending on the community and families being served; 4) Knowledge of the community, community organizations, and community leaders; 5)Ability to work flexible hours, including evening and weekend										

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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
hours.										
Task 1. Design workplan for deployment of CHW (workforce strategy).										
Task 2. Work in partnership with Cultural Competency/Health Literacy workstream to address cultural and linguistic needs.										
Task 3. Develop job description.										
Task 4. Develop employee evaluation process.										
Task 5. Employ qualified candidates.										
Task 6. Schedule/conduct onboarding training.										
Task 7. Assure training plan is in place for ongoing needs.										
Milestone #15 Establish protocols for deployment of CHW.										
Task PPS has established timelines to complete protocols (policies and procedures) for CHW program, including methods for new and ongoing training for CHWs.										
Task PPS has developed plans to develop operational program components of CHW.										
Task 1. Create list of needed policies/protocols with completion timeline.										
Task 2. Develop policies and protocols.										
Task 3. Approval process.										
Task 4. Coordinate with the Workforce Development Work Group as appropriate to determine training needs.										
Task 5. Schedule/conduct training.										
Task 6. Assure training plan is in place for ongoing needs.										
Task 7. Implement training for CHW.										
Task 8. Utilize planning team to develop workplan.										

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Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task 9. Work in partnership with 4.d.i. (Reduce Premature Births) and care management (ability to re-enforce applicable education).										
Task 10. Implement training (work in partnership with Cultural Competency/Health Literacy workstream to ensure training addresses cultural and linguistic needs).										
Task 11. Operationalize plan.										
Task 12. Deploy workers.										
Task 13. Develop QA process.										
Task 14. Implement QA process.										
Task 15. Update workplan document (deployment outlined).										
Milestone #16 Coordinate with the Medicaid Managed Care organizations serving the target population.										
Task PPS has established agreements with MCOs demonstrating coordination regarding CHW program, or attestation of intent to establish coverage agreements, as well as progress to date.										
Task 1. Coordinate Medicaid MCO outreach with project 2.a.i. (Integrated Delivery System) and the Value-Based Payment (VBP) Sub-Committee to coordinate and prioritize efforts across the projects.										
Task 2. Coordinate discussions with partnering PPSs as appropriate.										
Task 3. Present project and objectives to top four Medicaid MCOs serving WNY (Independent Health, Fidelis, Blue Cross Blue Shield, YourCare) within the monthly schedules and priorities created in 2.a.i. (coordinated effort with higher level leadership coordination).										
Task 4. Engage Medicaid MCOs in discussion for coverage agreements within the monthly schedules and priorities created in 2.a.i. (coordinated effort with higher level leadership coordination).										
Task 5. Continue dialogue to meet objectives including the metrics 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
outcomes to be evaluated.										
Task 6. Complete coverage agreements.										
Milestone #17 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. Define metrics.										
Task 2. Work in partnership with project 2.a.i. (Integrated Delivery System).										
Task 3. Determine data elements required.										
Task 4. Complete gap analysis (partner/CBO capabilities for EHR and data exchange).										
Task 5. Determine strategy.										
Task 6. Design training requirements.										
Task 7. Identify equipment needs.										
Task 8. Obtain and deploy equipment.										
Task 9. Schedule/conduct training.										
Task 10. Develop technical support process.										
Task 11. Design dashboard strategy for monitoring and QA.										

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 an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.										
Task PPS has developed a project plan that includes a timeline for implementation of an evidence-based home visiting model, such										

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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
as Nurse-Family Partnership visitation model, for this population.										
Milestone #2 Develop a referral system for early identification of women who are or may be at high-risk.										
Task PPS has developed a referral system for early identification of women who are or may be at high-risk.										
Milestone #3 Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.										
Task Membership of quality committee is representative of PPS staff involved in quality improvement processes and other stakeholders.										
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 Perinatal Care Metrics.										
Task Service and quality outcome measures are reported to all stakeholders.										
Milestone #4 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.										
Milestone #5 Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).										
Task PPS has identified and engaged with a regional medical center to address the care of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center). Assessment of the volume of high-risk pregnancies to be obtained through the CNA.										

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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 #6 Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.										
Task PPS has assembled a team of experts, including the number and type of experts and specialists and roles in the multidisciplinary team, to address the management of care of high-risk mothers and infants.										
Task PPS has established MOUs or joint operating agreements with substantive multidisciplinary team responsible for co-managing care of high-risk mothers and infants.										
Milestone #7 Develop service MOUs between multidisciplinary team and OB/GYN providers.										
Task PPS has identified and established MOUs or joint operating agreements between multidisciplinary team and OB/GYN providers.										
Milestone #8 Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.										
Task PPS has developed/adopted uniform clinical protocols guidelines based upon evidence-based standards agreed to by all partners.										
Task PPS has established best practice guidelines, policies and procedures, and plans for dissemination and training for interdisciplinary team on best practices.										
Task Training has been completed.										
Milestone #9 Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and	0	0	0	0	0	0	0	0	0	0

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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
SHIN-NY requirements.										
Task EHR or other IT platforms, meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	0	0
Task PPS uses alerts and secure messaging functionality.										
Milestone #10 Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR or other IT platforms meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	0	0	0
Milestone #11 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.										
Milestone #12 Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.										
Task PPS developed a work plan to use NYSDOH CHW training program and ensure CHW-trained members are integrated into the multidisciplinary team. PPS has obtained DOH funding for CHW training.										
Task 1. Select vendor(s) via RFQ/RFP process.										
Task 2. Identify work team participants.										
Task 3. Design CHW model program.										
Task 4. Define CHW role within the multidisciplinary team.										
Task 5. Define training needs for each role. Coordinate with the										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Workforce Development Work Group, as appropriate.										
Task 6. Work in partnership with Cultural Competency/Health Literacy workstream to address cultural and linguistic needs.										
Task 7. Schedule/conduct onboarding training.										
Task 8. Assure training plan is in place for ongoing needs.										
Task 9. Define ongoing education requirements. Coordinate with the Workforce Development Work Group, as appropriate.										
Task 10. Assure funding for training in place.										
Task 11. Complete work plan document.										
Milestone #13 Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.										
Task PPS has named assigned CHW Coordinator(s) or timeline for hiring CHW Coordinator(s).										
Task 1. Identify workgroup team.										
Task 2. Work in partnership with Cultural Competency/Health Literacy workstream to address cultural and linguistic needs.										
Task 3. Develop job description for CHW coordinator (supervisory).										
Task 4. Define staffing model utilizing DOH standards (1 supervisor to 4-6 CHWs).										
Task 5. Utilize data, CNA, and patient input to determine number of teams needed.										
Task 6. Develop employee evaluation process.										
Task 7. Employ qualified candidates.										
Task 8. Define training needs for role.										
Task 9. Schedule/conduct onboarding 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 10. Assure training plan is in place for ongoing needs.										
Task 11. Evaluate effectiveness and adjust as needed.										
Task 12. Complete staffing roster.										
Milestone #14 Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.										
Task PPS has developed a CHW workforce strategy and attendant qualifications of CHW(s) who meet the following criteria: 1) Indigenous community resident of the targeted area; 2) Writing ability sufficient to provide adequate documentation in the family record, referral forms and other service coordination forms, and reading ability to the level necessary to comprehend training materials and assist others to fill out forms; 3) Bilingual skills, depending on the community and families being served; 4) Knowledge of the community, community organizations, and community leaders; 5)Ability to work flexible hours, including evening and weekend hours.										
Task 1. Design workplan for deployment of CHW (workforce strategy).										
Task 2. Work in partnership with Cultural Competency/Health Literacy workstream to address cultural and linguistic needs.										
Task 3. Develop job description.										
Task 4. Develop employee evaluation process.										
Task 5. Employ qualified candidates.										
Task 6. Schedule/conduct onboarding training.										
Task 7. Assure training plan is in place for ongoing needs.										
Milestone #15 Establish protocols for deployment of CHW.										
Task PPS has established timelines to complete protocols (policies and procedures) for CHW program, including methods for new and ongoing training for CHWs.										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task PPS has developed plans to develop operational program components of CHW.										
Task 1. Create list of needed policies/protocols with completion timeline.										
Task 2. Develop policies and protocols.										
Task 3. Approval process.										
Task 4. Coordinate with the Workforce Development Work Group as appropriate to determine training needs.										
Task 5. Schedule/conduct training.										
Task 6. Assure training plan is in place for ongoing needs.										
Task 7. Implement training for CHW.										
Task 8. Utilize planning team to develop workplan.										
Task 9. Work in partnership with 4.d.i. (Reduce Premature Births) and care management (ability to re-enforce applicable education).										
Task 10. Implement training (work in partnership with Cultural Competency/Health Literacy workstream to ensure training addresses cultural and linguistic needs).										
Task 11. Operationalize plan.										
Task 12. Deploy workers.										
Task 13. Develop QA process.										
Task 14. Implement QA process.										
Task 15. Update workplan document (deployment outlined).										
Milestone #16 Coordinate with the Medicaid Managed Care organizations serving the target population.										
Task PPS has established agreements with MCOs demonstrating coordination regarding CHW program, or attestation of intent to										

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Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
establish coverage agreements, as well as progress to date.										
Task 1. Coordinate Medicaid MCO outreach with project 2.a.i. (Integrated Delivery System) and the Value-Based Payment (VBP) Sub-Committee to coordinate and prioritize efforts across the projects.										
Task 2. Coordinate discussions with partnering PPSs as appropriate.										
Task 3. Present project and objectives to top four Medicaid MCOs serving WNY (Independent Health, Fidelis, Blue Cross Blue Shield, YourCare) within the monthly schedules and priorities created in 2.a.i. (coordinated effort with higher level leadership coordination).										
Task 4. Engage Medicaid MCOs in discussion for coverage agreements within the monthly schedules and priorities created in 2.a.i. (coordinated effort with higher level leadership coordination).										
Task 5. Continue dialogue to meet objectives including the metrics and outcomes to be evaluated.										
Task 6. Complete coverage agreements.										
Milestone #17 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. Define metrics.										
Task 2. Work in partnership with project 2.a.i. (Integrated Delivery System).										
Task 3. Determine data elements required.										
Task 4. Complete gap analysis (partner/CBO capabilities for EHR and data exchange).										
Task 5. Determine strategy.										
Task 6. Design training requirements.										

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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 7. Identify equipment needs.										
Task 8. Obtain and deploy equipment.										
Task 9. Schedule/conduct training.										
Task 10. Develop technical support process.										
Task 11. Design dashboard strategy for monitoring and QA.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.	
Develop a referral system for early identification of women who are or may be at high-risk.	
Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.	
Use EHRs or other IT platforms to track all patients engaged in this project.	
Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).	
Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.	
Develop service MOUs between multidisciplinary team and OB/GYN providers.	

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Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.	
Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	
Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	
Use EHRs or other IT platforms to track all patients engaged in this project.	
Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.	Through RFP process, work was awarded to five organizations and has been initiated. Contracting is in progress.
Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.	Workgroup team identified and kicked off. Teams identified with coverage for the highest risk counties of WNY utilizing CNA (contracting in progress). Core training available and offered; core training is included for all coordinators.
Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.	All tasks progressing as expected.
Establish protocols for deployment of CHW.	Combined advisory workgroup in place; deployment initiated with established programs.
Coordinate with the Medicaid Managed Care organizations serving the target population.	All tasks progressing as expected.
Use EHRs or other IT platforms to track all patients engaged in this project.	All tasks progressing as expected.

Milestone Review Status

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

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Milestone Review Status

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

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

Instructions :

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Project 4.a.i – Promote mental, emotional and behavioral (MEB) well-being in communities

IPQR Module 4.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.

Mental, emotional, and behavioral (MEB) well-being media campaign fails to attain awareness levels among target audiences. Provide evidence-based (Substance Abuse and Mental Health Services Administration-approved) programs at targeted locations. Work with health literacy subject matter experts to develop programs that reflect cultural health literacy issues of target audiences. Test/pilot campaigns with focus groups to ensure effectiveness and appropriateness across various cultures, languages, socioeconomic, and geographic subgroups. Align with experts in public relations and marketing fields. Collaborate with established social science evaluators and website analytics experts to gather baseline data. Assess effectiveness of media campaign quarterly.

Programs are not age and/or culturally appropriate. Test/pilot programs with focus groups to gauge appropriateness. Provide cultural diversity and health literacy training to staff involved with the MEB well-being project. Leverage training and other activities that are part of project 2.d.i. (Patient Activation). Develop/facilitate initial training and provide ongoing training opportunities to staff at least quarterly. MEB well-being project leaders will meet routinely with members of the "Voice of the Consumer" Sub-Committee and CBO Task Force to obtain insights on what services will best meet the needs of those in specific community settings.

School-based MEB disorder prevention programs do not meet the projected level of engagement of clients and provide fewer than anticipated levels of referrals due to scheduling or engagement conflicts. Phase in programs over multiple years to lessen the risks of not reaching target audiences in educational settings. If school-based program schedules do not allow for engagement, target nearby community-based locations for programming, including after-school programs, YMCA recreational activities, sports programs, community centers, etc.

MEB health programs and services are duplicated by other agencies. Meet with Mental Health Association, ECCPASA, health plans, and other organizations to present details of the MEB well-being strategy, share information on targeted audiences, and explain messaging. The aim of sharing information on programs and targeted audiences will be to devise a comprehensive program that eliminates the possibility of service duplication and maximizes the benefits of a coordinated effort. This will be in coordination with the DOH Population Health Improvement Program which covers the same eight counties in the MCC PPS. The exchange of information on program activities and results among the MEB well-being program, health plans, and other groups will occur at least twice annually throughout this five-year project.

Stigma about accessing mental health or addiction treatment services prevents patients from taking advantage of these services. Lessen stigma via appropriate evidence-based messaging that is incorporated into wellness programs and media campaigns. Adapt programs to reflect demographic/cultural considerations; offer incentives to encourage participation. Test effectiveness of stigma-related messaging using focus groups, and partner with agencies experienced with multicultural populations to obtain continuous feedback. Support and empower MEB champions across the network to encourage participation among their peers. In the event that focus group results and outcome data show that existing stigma-related messaging is not effective, be prepared to examine shortfalls in existing strategy and make necessary revisions to

messaging and program approaches.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone [4ai_01] Identify and implement evidence-based practices and environmental strategies that promote MEB health. A menu of interventions is found on the Prevention Agenda website.	In Progress	[4ai_01] Identify and implement evidence-based practices and environmental strategies that promote MEB health. A menu of interventions is found on the Prevention Agenda website.	07/01/2015	03/29/2019	07/01/2015	03/29/2019	03/31/2019	DY4 Q4
Task 1. Convene a workgroup to discuss criteria needed for selecting a vendor. Solicit involvement from local agencies (e.g., Native American Community Services, WNY United, Compeer of Greater Buffalo, WNY Independent Living Center, Jewish Family Services, Chautauqua County Council, Cattaraugus County Council, Niagara County Council, and Mental Health Associations (MHA)s and substance abuse councils in all eight WNY counties). In addition Community Partners of WNY (CPWNY, led by Catholic Medical Partners) and MCC will identify the MHA of Erie County, and the Erie County Council for the Prevention of Alcohol and Substance Abuse (ECCPASA) as lead partners on this project.	Completed	1. Convene a workgroup to discuss criteria needed for selecting a vendor. Solicit involvement from local agencies (e.g., Native American Community Services, WNY United, Compeer of Greater Buffalo, WNY Independent Living Center, Jewish Family Services, Chautauqua County Council, Cattaraugus County Council, Niagara County Council, and Mental Health Associations (MHA)s and substance abuse councils in all eight WNY counties). In addition Community Partners of WNY (CPWNY, led by Catholic Medical Partners) and MCC will identify the MHA of Erie County, and the Erie County Council for the Prevention of Alcohol and Substance Abuse (ECCPASA) as lead partners on this project.	08/03/2015	08/21/2015	08/03/2015	08/21/2015	09/30/2015	DY1 Q2
Task 2. Conduct external workgroup meeting; review current direction/approach with workgroup.	Completed	2. Conduct external workgroup meeting; review current direction/approach with workgroup.	08/18/2015	09/08/2015	08/18/2015	09/08/2015	09/30/2015	DY1 Q2
Task 3. Select CBOs to implement evidence-based	Completed	3. Select CBOs to implement evidence-based programs via RFQ/RFP process or other action step. Preference will be given to	09/15/2015	09/30/2015	09/15/2015	09/30/2015	09/30/2015	DY1 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
programs via RFQ/RFP process or other action step. Preference will be given to contractor(s) capable of serving the 8 county region in collaboration with their identified partners.		contractor(s) capable of serving the 8 county region in collaboration with their identified partners.						
Task 4. Develop reporting requirements and metrics for each CBO.	Completed	4. Develop reporting requirements and metrics for each CBO.	09/15/2015	10/30/2015	09/15/2015	10/30/2015	12/31/2015	DY1 Q3
Task 5. Develop and execute contracts with CBOs (as applicable).	Completed	5. Develop and execute contracts with CBOs (as applicable).	09/15/2015	10/30/2015	09/15/2015	10/30/2015	12/31/2015	DY1 Q3
Task 6. Lead agencies will structure agreements (MOUs) with identified partners to formalize goals, schedules, and budgets. Potential new partners will be identified and engaged on an ongoing basis throughout the life of the project.	In Progress	6. Lead agencies will structure agreements (MOUs) with identified partners to formalize goals, schedules, and budgets. Potential new partners will be identified and engaged on an ongoing basis throughout the life of the project.	11/01/2015	03/31/2016	11/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 7. Work with selected contractors, P2 Collaborative, Community Partners of WNY (CPWNY, led by Catholic Medical Partners), county community action plans, and the Prevention Agenda website to identify tools that can measure community well-being.	In Progress	7. Work with selected contractors, P2 Collaborative, Community Partners of WNY (CPWNY, led by Catholic Medical Partners), county community action plans, and the Prevention Agenda website to identify tools that can measure community well-being.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 8. Use community needs assessment to identify priority needs and projects targeting programming at identified high-need and high-Medicaid attribution zip codes and school districts.	In Progress	8. Use community needs assessment to identify priority needs and projects targeting programming at identified high-need and high-Medicaid attribution zip codes and school districts.	07/27/2015	03/31/2016	07/27/2015	03/31/2016	03/31/2016	DY1 Q4
Task 9. Select programs from SAMHSA's approved registry related to four focus areas identified jointly with CPWNY: (a) prescription drug abuse, (b) child and adult depression, (c) substance abuse, and (d) suicide.	Completed	9. Select programs from SAMHSA's approved registry related to four focus areas identified jointly with CPWNY: (a) prescription drug abuse, (b) child and adult depression, (c) substance abuse, and (d) suicide.	07/27/2015	12/31/2015	07/27/2015	12/31/2015	12/31/2015	DY1 Q3

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 10. Host kickoff meeting of workgroup consisting of selected contractors, P2 Collaborative, Community Partners of WNY (CPWNY, led by Catholic Medical Partners), and other stakeholders. Workgroup will review "DSRIP Domain 4 and the Prevention Agenda: A Reference Guide for DSRIP Domain 4 Projects Implementation Planning" and other guidance as applicable.	Completed	10. Host kickoff meeting of workgroup consisting of selected contractors, P2 Collaborative, Community Partners of WNY (CPWNY, led by Catholic Medical Partners), and other stakeholders. Workgroup will review "DSRIP Domain 4 and the Prevention Agenda: A Reference Guide for DSRIP Domain 4 Projects Implementation Planning" and other guidance as applicable.	09/08/2015	12/31/2015	09/08/2015	12/31/2015	12/31/2015	DY1 Q3
Task 11. Provide administrative oversight to ensure implementation of evidence-based programming by community partners.	In Progress	11. Provide administrative oversight to ensure implementation of evidence-based programming by community partners.	10/02/2015	03/29/2019	10/02/2015	03/29/2019	03/31/2019	DY4 Q4
Task 12. Begin implementing and rolling out selected programs.	In Progress	12. Begin implementing and rolling out selected programs.	10/02/2015	03/29/2019	10/02/2015	03/29/2019	03/31/2019	DY4 Q4
Task 13. Continually engage additional partners, agencies, and other stakeholders as needed throughout the project, and establish MOUs when applicable.	In Progress	13. Continually engage additional partners, agencies, and other stakeholders as needed throughout the project, and establish MOUs when applicable.	10/02/2015	03/29/2019	10/02/2015	03/29/2019	03/31/2019	DY4 Q4
Task 14. Use community needs assessments and NYS DOH data to establish program/project benchmarks.	In Progress	14. Use community needs assessments and NYS DOH data to establish program/project benchmarks.	12/01/2015	03/31/2016	12/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task 15. Establish process measures and use them to track implementation success and short-term achievements. For example, track attendance at program-related events or educational sessions.	Not Started	15. Establish process measures and use them to track implementation success and short-term achievements. For example, track attendance at program-related events or educational sessions.	01/01/2016	03/29/2019	01/01/2016	03/29/2019	03/31/2019	DY4 Q4
Task 16. Set annual goals for program duration.	In Progress	16. Set annual goals for program duration.	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task 17. Measure program impact at annual intervals.	Not Started	17. Measure program impact at annual intervals.	04/01/2016	03/30/2018	04/01/2016	03/30/2018	03/31/2018	DY3 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Task 18. Make program adjustments as necessary.	Not Started	18. Make program adjustments as necessary.	04/01/2016	03/30/2018	04/01/2016	03/30/2018	03/31/2018	DY3 Q4
Task 19. Identify opportunities to integrate social determinants of health into existing and/or new programs: MCC PM will engage workgroup of MEB CBOs and partners to meet quarterly to discuss status, current opportunities, and priorities.	In Progress	19. Identify opportunities to integrate social determinants of health into existing and/or new programs: MCC PM will engage workgroup of MEB CBOs and partners to meet quarterly to discuss status, current opportunities, and priorities.	09/08/2015	03/29/2019	09/08/2015	03/29/2019	03/31/2019	DY4 Q4
Task 20. MCC and CPWNY public relations (PR) vendor(s) will be engaged.	In Progress	20. MCC and CPWNY public relations (PR) vendor(s) will be engaged.	11/02/2015	12/31/2015	11/02/2015	03/31/2016	03/31/2016	DY1 Q4
Task 21. PR firm(s) will research for the social stigma campaign focusing on general awareness campaign. They will provide creative development, production, PR, social media services, and website development for MCC and CPWNY.	In Progress	21. PR firm(s) will research for the social stigma campaign focusing on general awareness campaign. They will provide creative development, production, PR, social media services, and website development for MCC and CPWNY.	10/01/2015	03/29/2019	10/01/2015	03/29/2019	03/31/2019	DY4 Q4
Task 22. Use public awareness, education, and other programs to address and positively impact outcomes for the selected programs in the targeted population groups.	Not Started	22. Use public awareness, education, and other programs to address and positively impact outcomes for the selected programs in the targeted population groups.	01/04/2016	03/29/2019	01/04/2016	03/29/2019	03/31/2019	DY4 Q4
Milestone [4ai_02] Support and facilitate quality improvement of evidence-based practices and environmental strategies that promote MEB health.	In Progress	[4ai_02] Support and facilitate quality improvement of evidence-based practices and environmental strategies that promote MEB health.	07/01/2015	03/29/2019	07/01/2015	03/29/2019	03/31/2019	DY4 Q4
Task 1. Check program fidelity and collect pre- and post-test survey data annually beginning in July 2016.	Not Started	1. Check program fidelity and collect pre- and post-test survey data annually beginning in July 2016.	07/01/2016	03/29/2019	07/01/2016	03/29/2019	03/31/2019	DY4 Q4
Task 2. All participants will utilize knowledge and/or skills gained from specific training/program. Targeted number of individuals for each	In Progress	2. All participants will utilize knowledge and/or skills gained from specific training/program. Targeted number of individuals for each program TBD based on RFP response and capacity to serve 8 counties.	07/01/2015	03/29/2019	07/01/2015	03/29/2019	03/31/2019	DY4 Q4

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
program TBD based on RFP response and capacity to serve 8 counties.								
Task 3. Offer skill-building programs for elementary and middle school students (e.g., Too Good for Violence).	Not Started	3. Offer skill-building programs for elementary and middle school students (e.g., Too Good for Violence).	01/01/2016	03/29/2019	01/01/2016	03/29/2019	03/31/2019	DY4 Q4
Task 4. Offer skill-building programs for high school students (e.g., Teen Intervene).	Not Started	4. Offer skill-building programs for high school students (e.g., Teen Intervene).	01/01/2016	03/29/2019	01/01/2016	03/29/2019	03/31/2019	DY4 Q4
Task 5. Offer skill-building programs for adults (e.g., Wellness in the Workplace, Mental Health First Aid, parenting classes).	Not Started	5. Offer skill-building programs for adults (e.g., Wellness in the Workplace, Mental Health First Aid, parenting classes).	01/01/2016	03/29/2019	01/01/2016	03/29/2019	03/31/2019	DY4 Q4
Task 6. Identify and use process measures to evaluate the success of these skill-building programs (e.g., number of attendees, number of counties served, number of sessions).	Not Started	6. Identify and use process measures to evaluate the success of these skill-building programs (e.g., number of attendees, number of counties served, number of sessions).	01/01/2016	03/29/2019	01/01/2016	03/29/2019	03/31/2019	DY4 Q4
Task 7. Identify and use outcomes measures to evaluate effectiveness of these programs.	Not Started	7. Identify and use outcomes measures to evaluate effectiveness of these programs.	01/01/2016	03/29/2019	01/01/2016	03/29/2019	03/31/2019	DY4 Q4
Task 8. Promote and coordinate public awareness campaign/information for MEB.	In Progress	8. Promote and coordinate public awareness campaign/information for MEB.	10/01/2015	03/29/2019	10/01/2015	03/29/2019	03/31/2019	DY4 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
[4ai_01] Identify and implement evidence-based practices and environmental strategies that promote MEB health. A menu of	

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
interventions is found on the Prevention Agenda website.	
[4ai_02] Support and facilitate quality improvement of evidence-based practices and environmental strategies that promote MEB health.	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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Project 4.d.i – Reduce premature births

IPQR Module 4.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.

Some at-risk pregnant women may not comply with prenatal care standards. Sufficient resources must be allocated to provide management and support of at-risk pregnant women. Community health workers (CHWs) will be utilized to decrease barriers including referral to services and system navigation as well as to reinforce health education and preventive strategies. CHWs will be trained in and utilize Patient Activation Measures software to assess client motivation levels and guide appropriate interventions.

Without a central repository where project-specific outcome data is stored and analyzed, prenatal agencies serving the community are unable to measure how their work is contributing to overall metrics reported on by the NYS DOH. This project will establish data collection and reporting requirements and provide instruction to participating agency personnel on data analysis techniques so analytical functions can be integrated in their daily work and improvement strategies.

CHW is a lower-paid position which may experience high turnover rates; this can disrupt program operations, particularly when pregnant women lose their assigned workers. The project will require CHWs to complete training and certification. Certification will increase the status of workers, elevate their self-esteem, and curb turnover. Working in concert with the Workforce Development Work Group, CHWs will be encouraged to continue their education as pathways for advancement to supervisory positions or other related careers.

CHWs will not be able to adequately communicate with clients about risks that could endanger their or their baby's health if the training approach is over-generalized—not geared to the special needs of the population. It will be critical to develop and include specific modules in the training curriculum.

Third-party payer reimbursement for CHW services provided to pregnant women is imperative to the survival of the program at the end of the five-year waiver period. With its adherence to evidence-based protocols and heavy reliance on outcomes data, the project will routinely report outcomes to payers so they become well-educated on the effectiveness of the CHW approach to reducing premature births.

Project outcomes can be negatively impacted by reluctance among third-party payers to pay for at-home nursing care for pregnant women and to approve authorizations for prescription treatments that help maintain pregnancy to full-term. The project will prepare and submit information to health plans on the value of at-home nursing care and treatments for pregnant women and how this is an important component of a standardized, evidence-based protocol for avoiding premature births. Additionally, to increase accessibility to home nursing services and appropriate treatments, the project will work with health plans on streamlining the prior approval process for these services.

A lack of cooperation among WNY PPSs regarding the use of standardized protocols and policies related to this project could cause confusion among providers, prevent referrals, negatively impact reporting of data, and generally result in poor outcomes. The project is designed to serve all

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Medicaid-funded pregnant women regardless of what PPS they or their providers are affiliated with. To create a seamless transition for patients, MCC will work with partnering PPSs to utilize standardized referral protocols, use uniform tracking and reporting systems and procedures, and maintain common messaging to educate and communicate with patients.

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone [4di_01] Ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for smokers.	In Progress	Ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for smokers.	09/25/2015	03/31/2017	09/25/2015	03/31/2017	03/31/2017	DY2 Q4
Task 1. Determine PPS provider list.	In Progress	1. Determine PPS provider list.	09/25/2015	11/02/2015	09/25/2015	03/31/2016	03/31/2016	DY1 Q4
Task 2. Conduct a kickoff meeting with overview of program and goals; invite stakeholders.	In Progress	2. Conduct a kickoff meeting with overview of program and goals; invite stakeholders.	11/16/2015	01/29/2016	11/16/2015	01/29/2016	03/31/2016	DY1 Q4
Task 3. Determine stakeholders to develop planning team.	Completed	3. Determine stakeholders to develop planning team.	10/03/2016	10/28/2016	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task 4. Work in partnership with project 3.f.i. (Maternal Child Support/CHW program).	In Progress	4. Work in partnership with project 3.f.i. (Maternal Child Support/CHW program).	09/25/2015	03/31/2017	09/25/2015	03/31/2017	03/31/2017	DY2 Q4
Task 5. Evaluate best practice models. Determine model (e.g., Baby and Me Tobacco Free).	In Progress	5. Evaluate best practice models. Determine model (e.g., Baby and Me Tobacco Free).	02/15/2016	05/30/2016	10/01/2015	05/30/2016	06/30/2016	DY2 Q1
Task 6. Define protocol.	Not Started	6. Define protocol.	03/01/2016	06/01/2016	03/01/2016	06/01/2016	06/30/2016	DY2 Q1
Task 7. Determine training needs (offices, clinics, CHWs).	Not Started	7. Determine training needs (offices, clinics, CHWs).	03/01/2016	07/01/2016	03/01/2016	07/01/2016	09/30/2016	DY2 Q2
Task 8. Create/obtain written materials.	Not Started	8. Create/obtain written materials.	06/01/2016	08/01/2016	06/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task 9. Determine documentation needs (documentation and metrics to track, including QA system to monitor compliance).	Not Started	9. Determine documentation needs (documentation and metrics to track, including QA system to monitor compliance).	02/15/2016	07/30/2016	02/15/2016	07/30/2016	09/30/2016	DY2 Q2
Task	Not Started	10. Roll out training.	08/01/2016	09/28/2016	08/01/2016	09/28/2016	09/30/2016	DY2 Q2

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DSRIP Implementation Plan Project

Millennium Collaborative Care (PPS ID:48)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
10. Roll out training.								
Task 11. Adoption of protocol by providers.	Not Started	11. Adoption of protocol by providers.	08/01/2016	01/30/2017	08/01/2016	01/30/2017	03/31/2017	DY2 Q4
Task 12. Develop communication method or plan for CHW to assist with reinforcing education related to smoking behavior.	Not Started	12. Develop communication method or plan for CHW to assist with reinforcing education related to smoking behavior.	02/15/2016	08/01/2016	02/15/2016	08/01/2016	09/30/2016	DY2 Q2
Milestone [4di_02] Provide timely, continuous and comprehensive prenatal care services to pregnant women in accordance with NYS Medicaid prenatal care standards and other professional guidelines.	In Progress	Provide timely, continuous and comprehensive prenatal care services to pregnant women in accordance with NYS Medicaid prenatal care standards and other professional guidelines.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 1. Determine partner list (contacts and work team).	Completed	1. Determine partner list (contacts and work team).	09/25/2015	11/02/2015	09/25/2015	11/02/2015	12/31/2015	DY1 Q3
Task 2. Complete gap analysis.	Not Started	2. Complete gap analysis.	02/10/2016	02/12/2018	02/10/2016	02/12/2018	03/31/2018	DY3 Q4
Task 3. Determine list of protocols.	In Progress	3. Determine list of protocols.	12/01/2015	04/01/2016	12/01/2015	04/01/2016	06/30/2016	DY2 Q1
Task 4. Standardize protocols.	Not Started	4. Standardize protocols.	01/29/2016	06/30/2017	01/29/2016	06/30/2017	06/30/2017	DY3 Q1
Task 5. Determine/create tools and support needs.	Not Started	5. Determine/create tools and support needs.	02/10/2016	08/30/2017	02/10/2016	08/30/2017	09/30/2017	DY3 Q2
Task 6. Determine training needs (as protocols are completed and/or as a package).	Not Started	6. Determine training needs (as protocols are completed and/or as a package).	02/10/2016	08/30/2017	02/10/2016	08/30/2017	09/30/2017	DY3 Q2
Task 7. Implement training (dependent on needs).	Not Started	7. Implement training (dependent on needs).	04/01/2016	12/29/2017	04/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task 8. Adoption of protocols by providers.	Not Started	8. Adoption of protocols by providers.	02/10/2016	09/28/2018	02/10/2016	09/28/2018	09/30/2018	DY4 Q2
Task 9. Determine and implement reassessment/review process.	Not Started	9. Determine and implement reassessment/review process.	05/01/2017	08/30/2017	05/01/2017	08/30/2017	09/30/2017	DY3 Q2
Task 10. Consider recognition program with provider adoption and success.	Not Started	10. Consider recognition program with provider adoption and success.	01/01/2016	09/28/2018	01/01/2016	09/28/2018	09/30/2018	DY4 Q2
Task	Not Started	11. Assure ongoing touchpoints for feedback and evaluation.	10/02/2017	09/28/2018	10/02/2017	09/28/2018	09/30/2018	DY4 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
11. Assure ongoing touchpoints for feedback and evaluation.								
Milestone [4di_03] Work with paraprofessionals, including peer counselors, lay health advisors, and community health workers to reinforce health education and health care service utilization and enhance social support to high-risk pregnant women.	In Progress	Work with paraprofessionals, including peer counselors, lay health advisors, and community health workers to reinforce health education and health care service utilization and enhance social support to high-risk pregnant women.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 1. Work in partnership with 3fi Maternal Child support (CHW program)	In Progress	1. Work in partnership with 3fi Maternal Child support (CHW program)	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 2. Determine health education priorities.	Not Started	2. Determine health education priorities.	03/01/2016	08/01/2017	03/01/2016	08/01/2017	09/30/2017	DY3 Q2
Task 3. Determine communication and documentation methods.	Not Started	3. Determine communication and documentation methods.	04/01/2016	08/30/2017	04/01/2016	08/30/2017	09/30/2017	DY3 Q2
Task 4. Create/obtain tools and written materials.	Not Started	4. Create/obtain tools and written materials.	04/01/2016	09/29/2017	04/01/2016	09/29/2017	09/30/2017	DY3 Q2
Task 5. Standardize protocols.	Not Started	5. Standardize protocols.	04/01/2016	06/30/2017	04/01/2016	06/30/2017	06/30/2017	DY3 Q1
Task 6. Determine training needs (including ongoing education).	Not Started	6. Determine training needs (including ongoing education).	04/01/2016	08/30/2017	04/01/2016	08/30/2017	09/30/2017	DY3 Q2
Task 7. Implement training.	Not Started	7. Implement training.	04/01/2016	12/29/2017	04/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task 8. Implement program(s).	Not Started	8. Implement program(s).	04/01/2016	02/01/2018	04/01/2016	02/01/2018	03/31/2018	DY3 Q4
Task 9. Coordinate with participating counties Community Action Plans that selected a focus on preventing premature births.	In Progress	9. Coordinate with participating counties Community Action Plans that selected a focus on preventing premature births.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 10. Coordinate with P2 Collaborative community programs specific to preventing premature births, as applicable.	In Progress	10. Coordinate with P2 Collaborative community programs specific to preventing premature births, as applicable.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Milestone [4di_04] Implement innovative models of care	In Progress	Implement innovative models of care that demonstrated to improve preterm birth rates, and other adverse pregnancy outcomes	09/25/2015	08/24/2018	09/25/2015	08/24/2018	09/30/2018	DY4 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
that demonstrated to improve preterm birth rates, and other adverse pregnancy outcomes (prenatally, post-partum, family planning).		(prenatally, post-partum, family planning).						
Task 1. Utilize data to determine population needs/gaps.	In Progress	1. Utilize data to determine population needs/gaps.	09/25/2015	08/30/2016	09/25/2015	08/30/2016	09/30/2016	DY2 Q2
Task 2. Assess program models (determine fit and applicability to address outcome need).	In Progress	2. Assess program models (determine fit and applicability to address outcome need).	09/25/2015	01/29/2016	09/25/2015	01/29/2016	03/31/2016	DY1 Q4
Task 3. Engage partners to implement model(s).	In Progress	3. Engage partners to implement model(s).	11/02/2015	02/01/2018	11/02/2015	02/01/2018	03/31/2018	DY3 Q4
Task 4. Create protocols.	Not Started	4. Create protocols.	01/29/2016	06/30/2017	01/29/2016	06/30/2017	06/30/2017	DY3 Q1
Task 5. Determine training needs (including ongoing education).	Not Started	5. Determine training needs (including ongoing education).	04/01/2016	08/30/2017	04/01/2016	08/30/2017	09/30/2017	DY3 Q2
Task 6. Implement training.	Not Started	6. Implement training.	04/01/2016	12/29/2017	04/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task 7. Implement program model.	Not Started	7. Implement program model.	01/15/2016	02/01/2018	01/15/2016	02/01/2018	03/31/2018	DY3 Q4
Task 8. Determine metrics to determine success.	In Progress	8. Determine metrics to determine success.	09/25/2015	01/30/2017	09/25/2015	01/30/2017	03/31/2017	DY2 Q4
Milestone [4di_05] Provide clinical management of preterm labor in accordance with current clinical guidelines.	In Progress	Provide clinical management of preterm labor in accordance with current clinical guidelines.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 1. Engage Perinatal Center and perinatal subject matter experts.	In Progress	1. Engage Perinatal Center and perinatal subject matter experts.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 2. Standardize protocols.	Not Started	2. Standardize protocols.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task 3. Assess gaps and barriers.	Not Started	3. Assess gaps and barriers.	04/01/2016	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task 4. Identify and create needed tools/checklists.	Not Started	4. Identify and create needed tools/checklists.	04/01/2016	08/30/2017	04/01/2016	08/30/2017	09/30/2017	DY3 Q2
Task 5. Determine training needs.	Not Started	5. Determine training needs.	04/01/2016	08/30/2017	04/01/2016	08/30/2017	09/30/2017	DY3 Q2
Task	Not Started	6. Implement training.	04/01/2016	12/29/2017	04/01/2016	12/29/2017	12/31/2017	DY3 Q3

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6. Implement training.								
Task 7. Determine metrics to determine success.	In Progress	7. Determine metrics to determine success.	09/25/2015	01/30/2017	09/25/2015	01/30/2017	03/31/2017	DY2 Q4
Milestone [4di_06] Implement practices to expedite enrollment of low-income women in Medicaid, including presumptive eligibility for prenatal care and family planning coverage.	In Progress	Implement practices to expedite enrollment of low-income women in Medicaid, including presumptive eligibility for prenatal care and family planning coverage.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 1. Work in partnership with PAM project (alignment 2di).	In Progress	1. Work in partnership with PAM project (alignment 2di).	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 2. Work in partnership with 3fi Maternal Child support (CHW program).	In Progress	2. Work in partnership with 3fi Maternal Child support (CHW program).	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 3. Outline standardized process (protocol).	In Progress	3. Outline standardized process (protocol).	09/25/2015	04/01/2016	09/25/2015	04/01/2016	06/30/2016	DY2 Q1
Task 4. Assess implementation into this program (system gaps and barriers).	In Progress	4. Assess implementation into this program (system gaps and barriers).	09/25/2015	04/01/2016	09/25/2015	04/01/2016	06/30/2016	DY2 Q1
Task 5. Create implementation plan.	In Progress	5. Create implementation plan.	09/25/2015	04/01/2016	09/25/2015	04/01/2016	06/30/2016	DY2 Q1
Task 6. Assess training needs including whether there are additional components to consider for this population.	Not Started	6. Assess training needs including whether there are additional components to consider for this population.	04/01/2016	08/30/2017	04/01/2016	08/30/2017	09/30/2017	DY3 Q2
Task 7. Implement training.	Not Started	7. Implement training.	04/01/2016	12/29/2017	04/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task 8. Identify equipment needs.	In Progress	8. Identify equipment needs.	09/25/2015	04/01/2016	09/25/2015	04/01/2016	06/30/2016	DY2 Q1
Task 9. Deploy equipment.	Not Started	9. Deploy equipment.	04/01/2016	02/01/2018	04/01/2016	02/01/2018	03/31/2018	DY3 Q4
Task 10. Deploy enrollment procedures.	Not Started	10. Deploy enrollment procedures.	04/01/2016	12/29/2017	04/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task 11. Assure IT support and access needs are met.	Not Started	11. Assure IT support and access needs are met.	04/01/2016	09/28/2018	04/01/2016	09/28/2018	09/30/2018	DY4 Q2
Task 12. Monitor success.	Not Started	12. Monitor success.	02/01/2018	09/28/2018	02/01/2018	09/28/2018	09/30/2018	DY4 Q2

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Task 13. Create feedback system to identify previously unidentified or new barriers.	Not Started	13. Create feedback system to identify previously unidentified or new barriers.	02/01/2018	09/28/2018	02/01/2018	09/28/2018	09/30/2018	DY4 Q2
Milestone [4di_07] Utilize health information technology to facilitate more robust intake/enrollment, screening/risk assessment, referral, follow up and care coordination practices across health and human service providers.	In Progress	Utilize health information technology to facilitate more robust intake/enrollment, screening/risk assessment, referral, follow up and care coordination practices across health and human service providers.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 1. Work in partnership with integrated health system project (alignment 2ai).	In Progress	1. Work in partnership with integrated health system project (alignment 2ai).	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 2. Work in partnership with 3fi Maternal Child Support.	In Progress	2. Work in partnership with 3fi Maternal Child Support.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 3. Utilize EHR solution implemented across PPS.	Not Started	3. Utilize EHR solution implemented across PPS.	09/25/2015	11/02/2015	08/01/2016	09/28/2018	09/30/2018	DY4 Q2
Task 4. Identify metric needs.	In Progress	4. Identify metric needs.	12/31/2015	06/30/2016	12/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task 5. Work with vendor to assure metrics and reporting needs.	In Progress	5. Work with vendor to assure metrics and reporting needs.	09/25/2015	02/01/2016	09/25/2015	02/01/2016	03/31/2016	DY1 Q4
Task 6. Test system.	In Progress	6. Test system.	12/31/2015	08/01/2016	12/31/2015	08/01/2016	09/30/2016	DY2 Q2
Task 7. Determine educational needs.	In Progress	7. Determine educational needs.	12/31/2015	08/01/2016	12/31/2015	08/01/2016	09/30/2016	DY2 Q2
Task 8. Implement training.	In Progress	8. Implement training.	09/25/2015	10/28/2016	09/25/2015	10/28/2016	12/31/2016	DY2 Q3
Task 9. Create dashboard monitoring ability.	Not Started	9. Create dashboard monitoring ability.	10/28/2016	01/10/2017	10/28/2016	01/10/2017	03/31/2017	DY2 Q4
Task 10. Assess system and compliance gaps.	Not Started	10. Assess system and compliance gaps.	01/30/2017	08/28/2018	01/30/2017	08/28/2018	09/30/2018	DY4 Q2
Milestone [4di_08] Refer high-risk pregnant women to home visiting services in the community.	In Progress	Refer high-risk pregnant women to home visiting services in the community.	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2
Task 1. Work in partnership with home health	In Progress	1. Work in partnership with home health collaboration project (alignment 2bviii).	09/25/2015	09/28/2018	09/25/2015	09/28/2018	09/30/2018	DY4 Q2

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Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
collaboration project (alignment 2bviii).								
Task 2. Design criteria.	Not Started	2. Design criteria.	09/25/2015	08/01/2016	04/01/2016	08/01/2016	09/30/2016	DY2 Q2
Task 3. Determine training needs.	Not Started	3. Determine training needs.	04/01/2016	08/30/2017	04/01/2016	08/30/2017	09/30/2017	DY3 Q2
Task 4. Implement training.	Not Started	4. Implement training.	04/01/2016	01/15/2018	04/01/2016	01/15/2018	03/31/2018	DY3 Q4
Task 5. Implement plan.	Not Started	5. Implement plan.	08/01/2017	01/15/2018	08/01/2017	01/15/2018	03/31/2018	DY3 Q4
Task 6. Gap analysis (when services are not covered).	Not Started	6. Gap analysis (when services are not covered).	04/01/2016	12/29/2017	04/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task 7. Determine barriers to referrals.	Not Started	7. Determine barriers to referrals.	04/01/2016	12/29/2017	04/01/2016	12/29/2017	12/31/2017	DY3 Q3
Task 8. Engage Medicaid MCOs in discussion as needed (follow 3fi requirement 5 steps).	Not Started	8. Engage Medicaid MCOs in discussion as needed (follow 3fi requirement 5 steps).	04/01/2016	09/28/2018	04/01/2016	09/28/2018	09/30/2018	DY4 Q2

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
[4di_01] Ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for smokers.	First kickoff meeting with identified workteam took place on Nov. 30, 2015. Combined advisory workgroup has been identified and begun work.
[4di_02] Provide timely, continuous and comprehensive prenatal care services to pregnant women in accordance with NYS Medicaid prenatal care standards and other professional guidelines.	Advisory workgroup formed; full partner list in progress.
[4di_03] Work with paraprofessionals, including peer counselors, lay health advisors, and community health workers to reinforce health education and health care service utilization	Combined advisory workgroup in place.

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PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
and enhance social support to high-risk pregnant women.	
[4di_04] Implement innovative models of care that demonstrated to improve preterm birth rates, and other adverse pregnancy outcomes (prenatally, post-partum, family planning).	
[4di_05] Provide clinical management of preterm labor in accordance with current clinical guidelines.	
[4di_06] Implement practices to expedite enrollment of low-income women in Medicaid, including presumptive eligibility for prenatal care and family planning coverage.	Combined advisory workgroup in place.
[4di_07] Utilize health information technology to facilitate more robust intake/enrollment, screening/risk assessment, referral, follow up and care coordination practices across health and human service providers.	
[4di_08] Refer high-risk pregnant women to home visiting services in the community.	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

Instructions :

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

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Attestation

The Lead Representative has been designated by the Primary Lead PPS Provider (PPS Lead Entity) as the signing officiate for the DSRIP Quarterly Report. The Lead Representative has the authority to complete this attestation on behalf of the PPS network. The Lead Representative and PPS Lead Entity are responsible for the authenticity and accuracy of the material submitted in this report.

The Lead Representative of the Performing Provider System (PPS) must complete this attestation form in order for the project application to be accepted by the NYS Department of Health. Once the attestation is complete, the Quarterly Report will be locked down from any further editing. Do not complete this section until the entire Quarterly Report is complete.

If the Quarterly Report becomes locked in error and additional changes are necessary, please use the contact information on the Home Page to request that the Quarterly Report be unlocked.

To electronically sign this Quarterly Report, please enter the required information and check the box below:

☐ **I here by attest, as the Lead Representative of the 'Millennium Collaborative Care ', that all information provided on this Quarterly report is true and accurate to the best of my knowledge, and that, following initial submission in the current quarterly reporting period as defined by NY DOH, changes made to this report were pursuant only to documented instructions or documented approval of changes from DOH or DSRIP Independent Assessor.**

Primary Lead PPS Provider:	ERIE COUNTY MEDICAL CTR
Secondary Lead PPS Provider:	
Lead Representative:	Juan Santiago
Submission Date:	03/16/2016 04:58 PM

Comments:	

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Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	Juan Santiago	mrurak	03/31/2016 05:16 PM
DY1, Q3	Submitted	Juan Santiago	santiag7	03/16/2016 04:58 PM
DY1, Q3	Returned	Juan Santiago	mrurak	03/01/2016 05:15 PM
DY1, Q3	Submitted	Juan Santiago	santiag7	02/03/2016 01:53 PM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

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Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1Q3 Quarterly Report.	mrurak	03/31/2016 05:16 PM
Returned	The IA is returning the DY1Q3 Quarterly Report to the PPS for Remediation.	mrurak	03/01/2016 05:15 PM

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Section	Module Name	Status
Section 01	IPQR Module 1.1 - PPS Budget Report (Baseline)	Completed
	IPQR Module 1.2 - PPS Budget Report (Quarterly)	Completed
	IPQR Module 1.3 - PPS Flow of Funds (Baseline)	Completed
	IPQR Module 1.4 - PPS Flow of Funds (Quarterly)	Completed
	IPQR Module 1.5 - Prescribed Milestones	Completed
	IPQR Module 1.6 - PPS Defined Milestones	Completed
	IPQR Module 1.7 - IA Monitoring	
Section 02	IPQR Module 2.1 - Prescribed Milestones	Completed
	IPQR Module 2.2 - PPS Defined Milestones	Completed
	IPQR Module 2.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 2.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 2.5 - Roles and Responsibilities	Completed
	IPQR Module 2.6 - Key Stakeholders	Completed
	IPQR Module 2.7 - IT Expectations	Completed
	IPQR Module 2.8 - Progress Reporting	Completed
	IPQR Module 2.9 - IA Monitoring	
Section 03	IPQR Module 3.1 - Prescribed Milestones	Completed
	IPQR Module 3.2 - PPS Defined Milestones	Completed
	IPQR Module 3.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 3.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 3.5 - Roles and Responsibilities	Completed
	IPQR Module 3.6 - Key Stakeholders	Completed
	IPQR Module 3.7 - IT Expectations	Completed
	IPQR Module 3.8 - Progress Reporting	Completed
	IPQR Module 3.9 - IA Monitoring	
Section 04	IPQR Module 4.1 - Prescribed Milestones	Completed
	IPQR Module 4.2 - PPS Defined Milestones	Completed

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Section	Module Name	Status
	IPQR Module 4.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 4.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 4.5 - Roles and Responsibilities	Completed
	IPQR Module 4.6 - Key Stakeholders	Completed
	IPQR Module 4.7 - IT Expectations	Completed
	IPQR Module 4.8 - Progress Reporting	Completed
	IPQR Module 4.9 - IA Monitoring	
Section 05	IPQR Module 5.1 - Prescribed Milestones	Completed
	IPQR Module 5.2 - PPS Defined Milestones	Completed
	IPQR Module 5.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 5.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 5.5 - Roles and Responsibilities	Completed
	IPQR Module 5.6 - Key Stakeholders	Completed
	IPQR Module 5.7 - Progress Reporting	Completed
	IPQR Module 5.8 - IA Monitoring	
Section 06	IPQR Module 6.1 - Prescribed Milestones	Completed
	IPQR Module 6.2 - PPS Defined Milestones	Completed
	IPQR Module 6.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 6.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 6.5 - Roles and Responsibilities	Completed
	IPQR Module 6.6 - Key Stakeholders	Completed
	IPQR Module 6.7 - IT Expectations	Completed
	IPQR Module 6.8 - Progress Reporting	Completed
	IPQR Module 6.9 - IA Monitoring	
Section 07	IPQR Module 7.1 - Prescribed Milestones	Completed
	IPQR Module 7.2 - PPS Defined Milestones	Completed
	IPQR Module 7.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 7.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 7.5 - Roles and Responsibilities	Completed

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Section	Module Name	Status
	IPQR Module 7.6 - Key Stakeholders	Completed
	IPQR Module 7.7 - IT Expectations	Completed
	IPQR Module 7.8 - Progress Reporting	Completed
	IPQR Module 7.9 - IA Monitoring	
Section 08	IPQR Module 8.1 - Prescribed Milestones	Completed
	IPQR Module 8.2 - PPS Defined Milestones	Completed
	IPQR Module 8.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 8.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 8.5 - Roles and Responsibilities	Completed
	IPQR Module 8.6 - Key Stakeholders	Completed
	IPQR Module 8.7 - IT Expectations	Completed
	IPQR Module 8.8 - Progress Reporting	Completed
	IPQR Module 8.9 - IA Monitoring	
Section 09	IPQR Module 9.1 - Prescribed Milestones	Completed
	IPQR Module 9.2 - PPS Defined Milestones	Completed
	IPQR Module 9.3 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 9.4 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 9.5 - Roles and Responsibilities	Completed
	IPQR Module 9.6 - Key Stakeholders	Completed
	IPQR Module 9.7 - IT Expectations	Completed
	IPQR Module 9.8 - Progress Reporting	Completed
	IPQR Module 9.9 - IA Monitoring	
Section 10	IPQR Module 10.1 - Overall approach to implementation	Completed
	IPQR Module 10.2 - Major dependencies between work streams and coordination of projects	Completed
	IPQR Module 10.3 - Project Roles and Responsibilities	Completed
	IPQR Module 10.4 - Overview of key stakeholders and how influenced by your DSRIP projects	Completed
	IPQR Module 10.5 - IT Requirements	Completed
	IPQR Module 10.6 - Performance Monitoring	Completed
	IPQR Module 10.7 - Community Engagement	Completed

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Section	Module Name	Status
	IPQR Module 10.8 - IA Monitoring	
Section 11	IPQR Module 11.1 - Workforce Strategy Spending	Completed
	IPQR Module 11.2 - Prescribed Milestones	Completed
	IPQR Module 11.3 - PPS Defined Milestones	Completed
	IPQR Module 11.4 - Major Risks to Implementation & Risk Mitigation Strategies	Completed
	IPQR Module 11.5 - Major Dependencies on Organizational Workstreams	Completed
	IPQR Module 11.6 - Roles and Responsibilities	Completed
	IPQR Module 11.7 - Key Stakeholders	Completed
	IPQR Module 11.8 - IT Expectations	Completed
	IPQR Module 11.9 - Progress Reporting	Completed
	IPQR Module 11.10 - Staff Impact	Completed
	IPQR Module 11.11 - IA Monitoring	

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

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

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Section	Module Name / Milestone #	Review Status	
Section 01	Module 1.1 - PPS Budget Report (Baseline)	Pass & Complete	
	Module 1.2 - PPS Budget Report (Quarterly)	Pass & Ongoing	
	Module 1.3 - PPS Flow of Funds (Baseline)	Pass & Complete	
	Module 1.4 - PPS Flow of Funds (Quarterly)	Pass (with Exception) & Ongoing	IA
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Complete	
Section 02	Module 2.1 - Prescribed Milestones		
	Milestone #1 Finalize governance structure and sub-committee structure	Pass & Complete	
	Milestone #2 Establish a clinical governance structure, including clinical quality committees for each DSRIP project	Pass & Complete	
	Milestone #3 Finalize bylaws and policies or Committee Guidelines where applicable	Pass & Complete	
	Milestone #4 Establish governance structure reporting and monitoring processes	Pass & Complete	
	Milestone #5 Finalize community engagement plan, including communications with the public and non-provider organizations (e.g. schools, churches, homeless services, housing providers, law enforcement)	Pass & Ongoing	
	Milestone #6 Finalize partnership agreements or contracts with CBOs	Pass & Ongoing	
	Milestone #7 Finalize agency coordination plan aimed at engaging appropriate public sector agencies at state and local levels (e.g. local departments of health and mental hygiene, Social Services, Corrections, etc.)	Pass & Ongoing	
	Milestone #8 Finalize workforce communication and engagement plan	Pass & Ongoing	
	Milestone #9 Inclusion of CBOs in PPS Implementation.	Pass & Ongoing	
Section 03	Module 3.1 - Prescribed Milestones		
	Milestone #1 Finalize PPS finance structure, including reporting structure	Pass & Complete	
	Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	Pass & Ongoing	
	Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Pass & Complete	
	Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	Pass & Ongoing	
	Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	Pass & Ongoing	

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Section	Module Name / Milestone #	Review Status	
	Milestone #6 Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	Pass & Ongoing	
	Milestone #7 Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	Pass & Ongoing	
	Milestone #8 >=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	Pass & Ongoing	
Section 04	Module 4.1 - Prescribed Milestones		
	Milestone #1 Finalize cultural competency / health literacy strategy.	Fail	
	Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	Pass & Ongoing	
Section 05	Module 5.1 - Prescribed Milestones		
	Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	Pass & Ongoing	
	Milestone #2 Develop an IT Change Management Strategy.	Pass & Ongoing	
	Milestone #3 Develop roadmap to achieving clinical data sharing and interoperable systems across PPS network	Pass & Ongoing	
	Milestone #4 Develop a specific plan for engaging attributed members in Qualifying Entities	Pass & Ongoing	
	Milestone #5 Develop a data security and confidentiality plan.	Pass & Ongoing	
Section 06	Module 6.1 - Prescribed Milestones		
	Milestone #1 Establish reporting structure for PPS-wide performance reporting and communication.	Pass & Ongoing	
	Milestone #2 Develop training program for organizations and individuals throughout the network, focused on clinical quality and performance reporting.	Pass & Ongoing	
Section 07	Module 7.1 - Prescribed Milestones		
	Milestone #1 Develop Practitioners communication and engagement plan.	Pass & Ongoing	
	Milestone #2 Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	Pass & Ongoing	
Section 08	Module 8.1 - Prescribed Milestones		
	Milestone #1 Develop population health management roadmap.	Pass & Ongoing	
	Milestone #2 Finalize PPS-wide bed reduction plan.	Pass & Ongoing	
Section 09	Module 9.1 - Prescribed Milestones		
	Milestone #1 Perform a clinical integration 'needs assessment'.	Pass & Ongoing	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Ongoing	

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Section	Module Name / Milestone #	Review Status	
Section 11	Module 11.2 - Prescribed Milestones		
	Milestone #1 Define target workforce state (in line with DSRIP program's goals).	Pass & Ongoing	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Ongoing	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Ongoing	
	Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Pass & Ongoing	
	Milestone #5 Develop training strategy.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
2.a.i	Module 2.a.i.2 - Prescribed Milestones		
	Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.	Pass & Ongoing	
	Milestone #2 Utilize partnering HH and ACO population health management systems and capabilities to implement the PPS' strategy towards evolving into an IDS.	Pass & Ongoing	
	Milestone #3 Ensure patients receive appropriate health care and community support, including medical and behavioral health, post-acute care, long term care and public health services.	Pass & Ongoing	
	Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.	Pass & Ongoing	
	Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #6 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.	Pass & Ongoing	
	Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Pass & Ongoing	
	Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Pass & Ongoing	
	Milestone #10 Re-enforce the transition towards value-based payment reform by aligning provider compensation to patient outcomes.	Pass & Ongoing	
	Milestone #11 Engage patients in the integrated delivery system through outreach and navigation activities, leveraging community health workers, peers, and culturally competent community-based organizations, as appropriate.	Pass & Ongoing	
2.b.iii	Module 2.b.iii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.iii.3 - Prescribed Milestones		
	Milestone #1 Establish ED care triage program for at-risk populations	Pass & Ongoing	
	Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3.	Pass & Ongoing	

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	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		
	Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Pass & Ongoing	
	Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	Pass & Ongoing	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.b.vii	Module 2.b.vii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.vii.3 - Prescribed Milestones		
	Milestone #1 Implement INTERACT at each participating SNF, demonstrated by active use of the INTERACT 3.0 toolkit and other resources available at http://interact2.net.	Pass & Ongoing	
	Milestone #2 Identify a facility champion who will engage other staff and serve as a coach and leader of INTERACT program.	Pass & Ongoing	
	Milestone #3 Implement care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Pass & Ongoing	
	Milestone #4 Educate all staff on care pathways and INTERACT principles.	Pass & Ongoing	
	Milestone #5 Implement Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Pass & Ongoing	
	Milestone #6 Create coaching program to facilitate and support implementation.	Pass & Ongoing	
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Pass & Ongoing	
	Milestone #8 Establish enhanced communication with acute care hospitals, preferably with EHR and HIE connectivity.	Pass & Ongoing	
	Milestone #9 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Pass & Ongoing	
	Milestone #10 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.b.viii	Module 2.b.viii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.viii.3 - Prescribed Milestones		

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #1 Assemble Rapid Response Teams (hospital/home care) to facilitate patient discharge to home and assure needed home care services are in place, including, if appropriate, hospice.	Pass & Ongoing	
	Milestone #2 Ensure home care staff have knowledge and skills to identify and respond to patient risks for readmission, as well as to support evidence-based medicine and chronic care management.	Pass & Ongoing	
	Milestone #3 Develop care pathways and other clinical tools for monitoring chronically ill patients, with the goal of early identification of potential instability and intervention to avoid hospital transfer.	Pass & Ongoing	
	Milestone #4 Educate all staff on care pathways and INTERACT-like principles.	Pass & Ongoing	
	Milestone #5 Develop Advance Care Planning tools to assist residents and families in expressing and documenting their wishes for near end of life and end of life care.	Pass & Ongoing	
	Milestone #6 Create coaching program to facilitate and support implementation.	Pass & Ongoing	
	Milestone #7 Educate patient and family/caretakers, to facilitate participation in planning of care.	Pass & Ongoing	
	Milestone #8 Integrate primary care, behavioral health, pharmacy, and other services into the model in order to enhance coordination of care and medication management.	Pass & Ongoing	
	Milestone #9 Utilize telehealth/telemedicine to enhance hospital-home care collaborations.	Pass & Ongoing	
	Milestone #10 Utilize interoperable EHR to enhance communication and avoid medication errors and/or duplicative services.	Pass & Ongoing	
	Milestone #11 Measure outcomes (including quality assessment/root cause analysis of transfer) in order to identify additional interventions.	Pass & Ongoing	
	Milestone #12 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.d.i	Module 2.d.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.d.i.3 - Prescribed Milestones		
	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.	Pass & Ongoing	
	Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Pass & Complete	
	Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Pass & Ongoing	
	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	Pass & Ongoing	

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	plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.		
	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.	Pass & Ongoing	
	Milestone #8 Include beneficiaries in development team to promote preventive care.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Pass & Ongoing	
	Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Pass & Ongoing	
	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.	Pass & Ongoing	
3.a.i	Module 3.a.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.i.3 - Prescribed Milestones		
	Milestone #1 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.	Pass & Ongoing	
	Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Co-locate primary care services at behavioral health sites.	Pass & Ongoing	
	Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Pass & Ongoing	
	Milestone #7 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #9 Implement IMPACT Model at Primary Care Sites.	Pass & Ongoing	
	Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.	Pass & Ongoing	
	Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Pass & Ongoing	
	Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.	Pass & Ongoing	
	Milestone #13 Measure outcomes as required in the IMPACT Model.	Pass & Ongoing	
	Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Pass & Ongoing	
	Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.a.ii	Module 3.a.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.a.ii.3 - Prescribed Milestones		
	Milestone #1 Implement a crisis intervention program that, at a minimum, includes outreach, mobile crisis, and intensive crisis services.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	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.	Pass & Ongoing	
	Milestone #3 Establish agreements with the Medicaid Managed Care organizations serving the affected population to provide coverage for the service array under this project.	Pass & Ongoing	
	Milestone #4 Develop written treatment protocols with consensus from participating providers and facilities.	Pass & Ongoing	
	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.	Pass & Ongoing	
	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).	Pass & Ongoing	
	Milestone #7 Deploy mobile crisis team(s) to provide crisis stabilization services using evidence-based protocols developed by medical staff.	Pass & Ongoing	
	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.	Pass & Ongoing	
	Milestone #9 Establish central triage service with agreements among participating psychiatrists, mental health, behavioral health, and substance abuse providers.	Pass & Ongoing	
	Milestone #10 Ensure quality committee is established for oversight and surveillance of compliance with protocols and quality of care.	Pass & Ongoing	
	Milestone #11 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.b.i	Module 3.b.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.b.i.3 - Prescribed Milestones		
	Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Pass & Ongoing	
	Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Pass & Ongoing	
	Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	
	Milestone #15 Generate lists of patients with hypertension who have not had a recent visit and schedule a follow up visit.	Pass & Ongoing	
	Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Pass & Ongoing	
	Milestone #17 Perform additional actions including "hot spotting" strategies in high risk neighborhoods, linkages to Health Homes for the highest risk population, group visits, and implementation of the Stanford Model for chronic diseases.	Pass & Ongoing	
	Milestone #18 Adopt strategies from the Million Hearts Campaign.	Pass & Ongoing	
	Milestone #19 Form agreements with the Medicaid Managed Care organizations serving the affected population to coordinate services under this project.	Pass & Ongoing	
	Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Pass & Ongoing	
3.f.i	Module 3.f.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.f.i.3 - Prescribed Milestones		
	Milestone #1 Implement an evidence-based home visitation model, such as the Nurse Family Partnership, for pregnant high- risk mothers including high-risk first time mothers.	Pass & Ongoing	
	Milestone #2 Develop a referral system for early identification of women who are or may be at high-risk.	Pass & Ongoing	
	Milestone #3 Establish a quality oversight committee of OB/GYN and primary care providers to monitor quality outcomes and implement new or change activities as appropriate.	Pass & Ongoing	
	Milestone #4 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #5 Identify and engage a regional medical center with expertise in management of high-risk pregnancies and infants (must have Level 3 NICU services or Regional Perinatal Center).	Pass & Ongoing	
	Milestone #6 Develop a multidisciplinary team of experts with clinical and social support expertise who will co-manage care of the high-risk mother and infant with local community obstetricians and pediatric providers.	Pass & Ongoing	
	Milestone #7 Develop service MOUs between multidisciplinary team and OB/GYN providers.	Pass & Ongoing	

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Project ID	Module Name / Milestone #	Review Status	
	Milestone #8 Utilize best evidence care guidelines for management of high risk pregnancies and newborns and implement uniform clinical protocols based upon evidence-based guidelines.	Pass & Ongoing	
	Milestone #9 Ensure that all PPS safety net providers are actively sharing EHR systems or other IT platforms with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Pass & Ongoing	
	Milestone #10 Ensure that EHR systems or other IT platforms used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.	Pass & Ongoing	
	Milestone #11 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
	Milestone #12 Develop a Community Health Worker (CHW) program on the model of the Maternal and Infant Community Health Collaboratives (MICHC) program; access NYSDOH-funded CHW training program.	Pass & Ongoing	
	Milestone #13 Employ a Community Health Worker Coordinator responsible for supervision of 4 - 6 community health workers. Duties and qualifications are per NYS DOH criteria.	Pass & Ongoing	
	Milestone #14 Employ qualified candidates for Community Health Workers who meet criteria such as cultural competence, communication, and appropriate experience and training.	Pass & Ongoing	
	Milestone #15 Establish protocols for deployment of CHW.	Pass & Ongoing	
	Milestone #16 Coordinate with the Medicaid Managed Care organizations serving the target population.	Pass & Ongoing	
	Milestone #17 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
4.a.i	Module 4.a.i.2 - PPS Defined Milestones	Pass & Ongoing	
4.d.i	Module 4.d.i.2 - PPS Defined Milestones	Pass & Ongoing	