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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

TABLE OF CONTENTS

New York City Health and Hospitals Corporation (PPS ID:52)

New York City Health and Hospitals Corporation (PPS ID:52)

New York City Health and Hospitals Corporation (PPS ID:52)

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Quarterly Report - Implementation Plan for New York City Health and Hospitals Corporation

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

Status By Section

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

Status By Project

Project ID	Project Title	Status
2.a.i	Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management	Completed
2.a.iii	Health Home At-Risk Intervention Program: Proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services	Completed
2.b.iii	ED care triage for at-risk populations	Completed
2.b.iv	Care transitions intervention model to reduce 30 day readmissions for chronic health conditions	Completed
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.b.i	Evidence-based strategies for disease management in high risk/affected populations (adult only)	Completed
3.d.ii	Expansion of asthma home-based self-management program	Completed
3.g.i	Integration of palliative care into the PCMH Model	Completed
4.a.iii	Strengthen Mental Health and Substance Abuse Infrastructure across Systems	Completed
4.c.ii	Increase early access to, and retention in, HIV care	Completed

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	185,225,124	197,389,104	319,202,954	282,652,998	185,225,124	1,169,695,304
Cost of Project Implementation & Administration	**43,115,521**	**61,109,724**	**73,753,105**	**78,497,955**	**78,880,904**	**335,357,209**
Project Implementation	41,709,441	55,968,159	69,074,040	73,818,890	74,201,839	314,772,369
Administration	1,406,080	5,141,565	4,679,065	4,679,065	4,679,065	20,584,840
Revenue Loss	**0**	**13,449,415**	**40,348,245**	**40,348,245**	**40,348,245**	**134,494,150**
Internal PPS Provider Bonus Payments	**47,072,953**	**47,072,953**	**47,072,953**	**47,072,953**	**47,072,953**	**235,364,765**
Cost of non-covered services	**1,774,992**	**27,994,914**	**63,214,463**	**125,718,491**	**128,806,788**	**347,509,648**
Other	**18,522,512**	**19,738,910**	**31,920,295**	**28,265,300**	**18,522,512**	**116,969,529**
Contingency Fund	18,522,512	19,738,910	31,920,295	28,265,300	18,522,512	116,969,529
Total Expenditures	**110,485,978**	**169,365,916**	**256,309,061**	**319,902,944**	**313,631,402**	**1,169,695,301**
Undistributed Revenue	**74,739,146**	**28,023,188**	**62,893,893**	**0**	**0**	**3**

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

When compared with the approach articulated in the OneCity Health DSRIP application, budget estimates set out here reflect relative higher percentages for Project Implementation Costs and Costs for Services Not Covered, and lower relative percentages for the Revenue Loss and Bonus Pool categories. This variance stems from a variety of factors:

1. These estimates reflect costs net of Inter-governmental Transfers (IGT).

2. The budget estimates set out here are based on the most recent projections of resources required to fulfill the state mandated project

New York City Health and Hospitals Corporation (PPS ID:52)

requirements and performance targets and successfully achieve the objectives outlined in OneCity Health's DSRIP application. These estimates were built upon individual workflows within the DSRIP projects, focusing on Project Implementation Costs and Costs for Uncovered Services. The estimates are preliminary and will continue to evolve as the PPS works with its partners to better understand program and implementation requirements.

3. These estimates take into account OneCity Health's maximum total valuation figures communicated by the DOH on May 7th, which reflected a lower amount than anticipated given the proportion of New York State Medicaid patients served by OneCity Health.

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
185,225,124	1,169,695,304	185,225,124	1,169,695,304

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	**0**	**0**	**43,115,521**	**100.00%**	**335,357,209**	**100.00%**
Project Implementation	0					
Administration	0					
Revenue Loss	**0**	**0**	**0**		**134,494,150**	**100.00%**
Internal PPS Provider Bonus Payments	**0**	**0**	**47,072,953**	**100.00%**	**235,364,765**	**100.00%**
Cost of non-covered services	**0**	**0**	**1,774,992**	**100.00%**	**347,509,648**	**100.00%**
Other	**0**	**0**	**18,522,512**	**100.00%**	**116,969,529**	**100.00%**
Contingency Fund	0					
Total Expenditures	**0**	**0**				

Current File Uploads

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No Records Found

Narrative Text :

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

OneCity Health's actual budget and funds flow spend is subject to vetting and approval by the PPS Executive Committee, as well as the execution of the PPS Master Services Agreement and accompanying project-specific schedules with PPS partners, including the PPS lead, NYC Health + Hospitals. OneCity Health does not have actual spend to report at this time, pending the execution of these contracts and the finalization of the PPS budget and funds flow plan.

The Cost of Administration has been reported separate from other Cost of Project Implementation. In the absence of an official definition for the 'Cost of Administration,' OneCity Health considers Cost of Administration to reflect the management functions served by OneCity Health Services (the PPS Central Services Organization) that are not specific to the operational implementation of clinical projects or PPS partner management at the hub level. Examples of Cost of Administration include communications, finance, administrative support, and certain senior leadership functions.

The 'Other' budget category for the OneCity Health PPS is made up of a contingency fund, which represents a 10 percent allocation of funds to account for uncertainty in projecting anticipated funds flow and earned revenue at this stage in the DSRIP planning and implementation process.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	185,225,124	197,389,104	319,202,954	282,652,998	185,225,124	1,169,695,304
Practitioner - Primary Care Provider (PCP)	2,793,672	3,956,250	5,593,429	7,533,332	7,632,017	27,508,700
Practitioner - Non-Primary Care Provider (PCP)	2,722,351	3,615,736	4,913,670	6,225,573	6,291,970	23,769,300
Hospital	43,432,337	65,905,162	100,089,247	110,428,031	111,085,607	430,940,384
Clinic	10,239,448	16,379,860	23,776,469	34,094,212	34,633,948	119,123,937
Case Management / Health Home	8,479,864	23,830,873	43,886,791	78,852,633	80,583,457	235,633,618
Mental Health	10,540,612	13,814,253	18,142,181	22,105,922	22,287,652	86,890,620
Substance Abuse	1,412,189	1,815,671	2,622,636	2,622,636	2,622,636	11,095,768
Nursing Home	3,672,802	5,205,388	7,365,003	7,924,029	7,942,239	32,109,461
Pharmacy	1,412,189	1,412,189	1,412,189	1,412,189	1,412,189	7,060,945
Hospice	1,148,913	1,675,936	2,458,315	2,626,023	2,631,486	10,540,673
Community Based Organizations	4,703,010	6,874,122	9,449,772	13,134,000	13,306,625	47,467,529
All Other	18,522,512	19,738,910	31,920,295	28,265,300	18,522,512	116,969,529
PPS PMO	1,406,080	5,141,565	4,679,065	4,679,065	4,679,065	20,584,840
Total Funds Distributed	**110,485,979**	**169,365,915**	**256,309,062**	**319,902,945**	**313,631,403**	**1,169,695,304**
Undistributed Revenue	**74,739,145**	**28,023,189**	**62,893,892**	**0**	**0**	**0**

Current File Uploads

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

The forecast funds flow set out here is consistent with the approach to the distribution of DSRIP funds articulated in the OneCity Health DSRIP application. However it should be noted that the "Hospitals" and "Clinics" categories include primary care physicians, non-PCP practitioners, behavioral health providers, etc., who are employed by HHC or SUNY. In addition, the "Health Home/Care Management" category is assumed to incorporate several provider classes engaged in the provision of care management services.

Module Review Status

Review Status	IA Formal Comments
Pass & Complete	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
185,225,124	1,169,695,304	185,225,124	1,169,695,304

Funds Flow Items	DY1 Q3 Quarterly Amount - Update	Total Amount Disbursed	Percent Spent By Project										DY Adjusted Difference	Cumulative Difference
			Projects Selected By PPS											
			2.a.i	2.a.iii	2.b.iii	2.b.iv	2.d.i	3.a.i	3.b.i	3.d.ii	3.g.i	4.a.iii	4.c.ii	
Practitioner - Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	0	2,793,672	27,508,700
Practitioner - Non-Primary Care Provider (PCP)	0	0	0	0	0	0	0	0	0	0	0	0	0	2,722,351	23,769,300
Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	43,432,337	430,940,384
Clinic	0	0	0	0	0	0	0	0	0	0	0	0	0	10,239,448	119,123,937
Case Management / Health Home	0	0	0	0	0	0	0	0	0	0	0	0	0	8,479,864	235,633,618
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0	10,540,612	86,890,620
Substance Abuse	0	0	0	0	0	0	0	0	0	0	0	0	0	1,412,189	11,095,768
Nursing Home	0	0	0	0	0	0	0	0	0	0	0	0	0	3,672,802	32,109,461
Pharmacy	0	0	0	0	0	0	0	0	0	0	0	0	0	1,412,189	7,060,945
Hospice	0	0	0	0	0	0	0	0	0	0	0	0	0	1,148,913	10,540,673
Community Based Organizations	0	0	0	0	0	0	0	0	0	0	0	0	0	4,703,010	47,467,529
All Other	0	0	0	0	0	0	0	0	0	0	0	0	0	18,522,512	116,969,529
PPS PMO	0	0												1,406,080	20,584,840
Total Funds Distributed	**0**	**0**													

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date

No Records Found

Narrative Text :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

OneCity Health's actual budget and funds flow spend is subject to vetting and approval by the PPS Executive Committee, as well as the execution of the PPS Master Services Agreement and accompanying project-specific schedules with PPS partners, including the PPS lead, NYC Health + Hospitals. OneCity Health does not have actual spend to report at this time, pending the execution of these contracts and the finalization of the PPS budget and funds flow plan.

Based on recent guidance from NYS DOH, all costs incurred by OneCity Health Services (the PPS Central Services Organization), which include costs associated with project implementation, hub operations, and infrastructure to support the PPS, have been shifted from "All Other" to the "Hospitals" category (the provider classification assigned by NYS DOH to the PPS fiduciary lead NYC Health + Hospitals). In addition, based on the NYS DOH provider classification types, it should be noted that the "Hospitals" and "Clinics" categories include primary care physicians (PCP), non-PCP practitioners, behavioral health providers, etc., who are employed by NYC Health + Hospitals or SUNY. The "Health Home/Care Management" category is understood to represent various types of care models (e.g. centralized or locally-deployed) and provider classes engaged in the provision of care management services.

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	In Progress	Funds Flow Budget and Distribution Plan, signed off by your Finance Committee, including details of your approach to funds flow on a whole-PPS and project-by-project basis; evidence of involvement of provider network in developing funds flow methodology.	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1: Conduct detailed survey/assessment of existing partner resources and capabilities.	Completed	Step 1: Conduct detailed survey/assessment of existing partner resources and capabilities.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Define project-level requirements by provider type through a hub-based planning process.	Completed	Step 2: Define project-level requirements by provider type through a hub-based planning process.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Engage in partner contracting process through execution of Master Services Agreement and begin execution of project-specific schedules on a rolling basis in accordance with project initiation timeline.	Completed	Step 3: Engage in partner contracting process through execution of Master Services Agreement and begin execution of project-specific schedules on a rolling basis in accordance with project initiation timeline.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Draft PPS Budget and Funds Flow distribution plan.	In Progress	Step 4: Draft PPS Budget and Funds Flow distribution plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Review and recommendation of PPS Budget and Funds Flow distribution plan by Business Operations & Information Technology Subcommittee.	In Progress	Step 5: Review and recommendation of PPS Budget and Funds Flow distribution plan by Business Operations & Information Technology Subcommittee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6: Review and approval of PPS Budget and Funds Flow distribution plan by PPS Executive	In Progress	Step 6: Review and approval of PPS Budget and Funds Flow distribution plan by PPS Executive Committee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.									

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

Prescribed Milestones Narrative Text

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

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 1.7 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 02 – Governance

IPQR Module 2.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize governance structure and sub-committee structure	Completed	This milestone must be completed by 9/30/2015. Governance and committee structure, signed off by PPS Board.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	YES
Task Step 1: Appoint members of the PPS Executive Committee.	Completed	Step 1: Appoint members of the PPS Executive Committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2: Convene PPS Executive Committee and initiate committee work.	Completed	Step 2: Convene PPS Executive Committee and initiate committee work.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 3: Develop and finalize charters for PPS Executive Committee, Nominating Committee, Care Models Subcommittee, Stakeholder & Patient Engagement Subcommittee, Business Operations & Information Technology Subcommittee, and Hub Steering Committees (collectively, the "Governance Charters"). The Governance Charters will describe the responsibilities of each committee, the process for appointing members to each committee, and the consensus-based decision making process of each committee.	Completed	Step 3: Develop and finalize charters for PPS Executive Committee, Nominating Committee, Care Models Subcommittee, Stakeholder & Patient Engagement Subcommittee, Business Operations & Information Technology Subcommittee, and Hub Steering Committees (collectively, the "Governance Charters"). The Governance Charters will describe the responsibilities of each committee, the process for appointing members to each committee, and the consensus-based decision making process of each committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 4: PPS Executive Committee and HHC will approve all Governance Charters.	Completed	Step 4: PPS Executive Committee and HHC will approve all Governance Charters.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task	Completed	Step 5: Appoint initial members of the Nominating Committee,	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 5: Appoint initial members of the Nominating Committee, Care Models Subcommittee, Stakeholder & Patient Engagement Subcommittee, Business Operations & Information Technology Subcommittee, and Hub Steering Committees (collectively, the "Subcommittees"). The Hub Steering Committees will be responsible providing local leadership of DSRIP-related activities and reporting back to the PPS-wide committees on local issues and best practices. Appoint Compliance Officer (within HHC Compliance function).		Care Models Subcommittee, Stakeholder & Patient Engagement Subcommittee, Business Operations & Information Technology Subcommittee, and Hub Steering Committees (collectively, the "Subcommittees"). The Hub Steering Committees will be responsible providing local leadership of DSRIP-related activities and reporting back to the PPS-wide committees on local issues and best practices. Appoint Compliance Officer (within HHC Compliance function).							
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	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1: Develop and finalize charter for Care Models Subcommittee. The charter will describe the responsibilities of the Care Models Subcommittee, the process for appointing members to the Care Models Subcommittee, and the consensus-based decision making process of the Care Models Subcommittee. PPS Executive Committee and HHC will approve the charter. The Care Models Subcommittee will provide clinical governance and quality oversight for all DSRIP projects in conjunction with the PPS Chief Clinical Officer.	Completed	Step 1: Develop and finalize charter for Care Models Subcommittee. The charter will describe the responsibilities of the Care Models Subcommittee, the process for appointing members to the Care Models Subcommittee, and the consensus-based decision making process of the Care Models Subcommittee. PPS Executive Committee and HHC will approve the charter. The Care Models Subcommittee will provide clinical governance and quality oversight for all DSRIP projects in conjunction with the PPS Chief Clinical Officer.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Solicit and appoint members of the Care Models Subcommittee.	Completed	Step 2: Solicit and appoint members of the Care Models Subcommittee.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Convene Care Models Subcommittee, review charter, and initiate Care Models Subcommittee work.	Completed	Step 3: Convene Care Models Subcommittee, review charter, and initiate Care Models Subcommittee work.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Develop and finalize initial clinical guidelines for each project based on recommendations of ad-hoc project-specific Clinical Leadership Team workgroups. Review of guidelines by Care Models Subcommittee, Project Advisory Committee, and Executive Committee. Care Models Committee will further refine clinical guidelines over time, convening ad-hoc sub-workgroups as needed.	Completed	Step 4: Develop and finalize initial clinical guidelines for each project based on recommendations of ad-hoc project-specific Clinical Leadership Team workgroups. Review of guidelines by Care Models Subcommittee, Project Advisory Committee, and Executive Committee. Care Models Committee will further refine clinical guidelines over time, convening ad-hoc sub-workgroups as needed.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 5: Appoint PPS Chief Clinical Officer.	Completed	Step 5: Appoint PPS Chief Clinical Officer.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6: Develop and finalize initial clinical guidelines for each project. Care Models Subcommittee and Executive Committee will approve clinical guidelines.	Completed	Step 6: Develop and finalize initial clinical guidelines for each project. Care Models Subcommittee and Executive Committee will approve clinical guidelines.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 7: Establish process and schedule to review and revise/update clinical guidelines on an as needed basis.	Completed	Step 7: Establish process and schedule to review and revise/update clinical guidelines on an as needed basis.	10/01/2015	12/31/2015	10/01/2015	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.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	YES
Task Step 1: Develop and finalize approval of Governance Charters, which are the functional equivalent of by-laws and Committee Guidelines for the PPS governance structure.	Completed	Step 1: Develop and finalize approval of Governance Charters, which are the functional equivalent of by-laws and Committee Guidelines for the PPS governance structure.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2: Share Governance Charters with other Subcommittees and partner organizations.	Completed	Step 2: Share Governance Charters with other Subcommittees and partner organizations.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Establish process to review and revise/update Charters on an annual or as needed basis.	Completed	Step 3: Establish process to review and revise/update Charters on an annual or as needed basis.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Milestone #4	Completed	This milestone must be completed by 12/31/2015.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Establish governance structure reporting and monitoring processes		Governance and committee structure document, including description of two-way reporting processes and governance monitoring processes							
Task Step 1: Draft procedures by which the PPS Executive Committee and Subcommittees will (a) keep minutes, (b) send minutes and supporting meeting materials to the Executive Committee, other Subcommittees, as applicable, and (c) make minutes, and meeting materials, as appropriate, available to partner organizations ("Reporting Process").	Completed	Step 1: Draft procedures by which the PPS Executive Committee and Subcommittees will (a) keep minutes, (b) send minutes and supporting meeting materials to the Executive Committee, other Subcommittees, as applicable, and (c) make minutes, and meeting materials, as appropriate, available to partner organizations ("Reporting Process").	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Establish electronic governance portal to post minutes from Executive Committee and Subcommittees.	Completed	Step 2: Establish electronic governance portal to post minutes from Executive Committee and Subcommittees.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Establish process to monitor and revise Reporting Process as needed to ensure effective governance of PPS.	Completed	Step 3: Establish process to monitor and revise Reporting Process as needed to ensure effective governance of PPS.	10/01/2015	12/31/2015	10/01/2015	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.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Determine which types of organizations benefit from PPS engagement at a hub-level vs. a City-wide level.	In Progress	Step 1: Determine which types of organizations benefit from PPS engagement at a hub-level vs. a City-wide level.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 2: For hub-level engagement targets, identify existing engagement channels between hub partners (e.g., hospitals, FQHCs, CBOs) and public/non-provider organizations, including the feasibility of leveraging those channels for PPS engagement.	In Progress	Step 2: For hub-level engagement targets, identify existing engagement channels between hub partners (e.g., hospitals, FQHCs, CBOs) and public/non-provider organizations, including the feasibility of leveraging those channels for PPS engagement.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task	In Progress	Step 3: Segment remaining other public and non-provider	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3: Segment remaining other public and non-provider organizations by most appropriate two-way engagement channel (e.g., in-person forums, web portal).		organizations by most appropriate two-way engagement channel (e.g., in-person forums, web portal).							
Task Step 4: Design Community Engagement Plan, including two-way communication with stakeholder groups and accounting for hub-level and City-wide level engagement needs.	In Progress	Step 4: Design Community Engagement Plan, including two-way communication with stakeholder groups and accounting for hub-level and City-wide level engagement needs.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Community Engagement Plan reviewed and recommended by Stakeholder & Patient Engagement Subcommittee.	In Progress	Step 5: Community Engagement Plan reviewed and recommended by Stakeholder & Patient Engagement Subcommittee.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 6: Community Engagement plan reviewed and approved by PPS Executive Committee.	In Progress	Step 6: Community Engagement plan reviewed and approved by PPS Executive Committee.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Milestone #6 Finalize partnership agreements or contracts with CBOs	In Progress	Signed CBO partnership agreements or contracts.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: Draft Master Services Agreement and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure (collectively, the "Base Agreement").	Completed	Step 1: Draft Master Services Agreement and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure (collectively, the "Base Agreement").	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Solicit comments from partners.	Completed	Step 2: Solicit comments from partners.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Finalize Base Agreement.	Completed	Step 3: Finalize Base Agreement.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Execute Base Agreements.	In Progress	Step 4: Execute Base Agreements.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Begin development and execution of first project-specific schedules for certain partners, as appropriate, in accordance with project initiation timeline.	In Progress	Step 5: Begin development and execution of first project-specific schedules for certain partners, as appropriate, in accordance with project initiation timeline.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task	In Progress	Step 6: Execute agreements.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 6: Execute agreements.									
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.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Identify key public sector agency stakeholders not already affiliated with the OneCity Health PPS Project Advisory Committee (PAC) or other governance structures.	Completed	Step 1: Identify key public sector agency stakeholders not already affiliated with the OneCity Health PPS Project Advisory Committee (PAC) or other governance structures.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Conduct series of discussions with key leaders not already in close affiliation with OneCity Health to identify the full range of collaboration opportunities across programs.	In Progress	Step 2: Conduct series of discussions with key leaders not already in close affiliation with OneCity Health to identify the full range of collaboration opportunities across programs.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Create Agency Coordination Plan.	In Progress	Step 3: Create Agency Coordination Plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Agency Coordination Plan reviewed and recommended by Stakeholder & Patient Engagement Subcommittee.	In Progress	Step 4: Agency Coordination Plan reviewed and recommended by Stakeholder & Patient Engagement Subcommittee.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: Agency Coordination Plan reviewed and approved by PPS Executive Committee.	In Progress	Step 5: Agency Coordination Plan reviewed and approved by PPS Executive Committee.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
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).	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Based on current state workforce assessment report & gap analysis, and training strategy, as well as overall PPS project implementation strategy, identify key elements and timing of workforce communication and engagement plan.	In Progress	Step 1: Based on current state workforce assessment report & gap analysis, and training strategy, as well as overall PPS project implementation strategy, identify key elements and timing of workforce communication and engagement plan.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Leverage the Hub-based PPS structure to identify local workforce communication needs, building on existing stakeholder constituency groups such as the HHC Speakers Bureau; hub-specific communication needs will depend on pace and timing of DSRIP project implementation in each area.	In Progress	Step 2: Leverage the Hub-based PPS structure to identify local workforce communication needs, building on existing stakeholder constituency groups such as the HHC Speakers Bureau; hub-specific communication needs will depend on pace and timing of DSRIP project implementation in each area.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3: Develop workforce communication and engagement plan in collaboration with labor union partners and other stakeholders, with focus on key changes anticipated as part of DSRIP program implementation as well as key features of PPS workforce strategy. Revise plan on an ongoing basis in collaboration with stakeholders.	In Progress	Step 3: Develop workforce communication and engagement plan in collaboration with labor union partners and other stakeholders, with focus on key changes anticipated as part of DSRIP program implementation as well as key features of PPS workforce strategy. Revise plan on an ongoing basis in collaboration with stakeholders.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 4: Present workforce communication and engagement plan to PPS Executive Committee for review and approval.	In Progress	Step 4: Present workforce communication and engagement plan to PPS Executive Committee for review and approval.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	
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	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: CBO outreach and engagement to better understand how existing scope(s) of service relate to community need and align with programmatic interventions across patient settings. Engagement activities to-date include: - CBO Townhall Meetings (webinars) - General and project-focused meetings with CBO delegations - PPS PAC meetings with broad CBO participation	Completed	Step 1: CBO outreach and engagement to better understand how existing scope(s) of service relate to community need and align with programmatic interventions across patient settings. Engagement activities to-date include: - CBO Townhall Meetings (webinars) - General and project-focused meetings with CBO delegations - PPS PAC meetings with broad CBO participation	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task	Completed	Step 2: Develop Partner Readiness Assessment Tool	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 2: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on PPS network capacity and capabilities, including CBOs. Educate CBO partners on PRAT via webinar; provide ongoing phone-based support as needed.		(PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on PPS network capacity and capabilities, including CBOs. Educate CBO partners on PRAT via webinar; provide ongoing phone-based support as needed.							
Task Step 3: Develop inclusive PPS governance structure with range of partner types and expertise, with CBO representation on each governance committee.	Completed	Step 3: Develop inclusive PPS governance structure with range of partner types and expertise, with CBO representation on each governance committee.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 4: Hire Senior Director of Engagement and Collaborations, who has primary responsibility of facilitating design and implementation of cultural competency programming, and for the oversight of CBO and other partner participation in achieving Project 11 program goals.	Completed	Step 4: Hire Senior Director of Engagement and Collaborations, who has primary responsibility of facilitating design and implementation of cultural competency programming, and for the oversight of CBO and other partner participation in achieving Project 11 program goals.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 5: Solicit feedback and questions from CBOs on Master Services Agreements and exhibits (collectively, the "Base Agreement") and finalize agreement.	Completed	Step 5: Solicit feedback and questions from CBOs on Master Services Agreements and exhibits (collectively, the "Base Agreement") and finalize agreement.	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 6: Execute Base Agreements with ~65 CBOs.	In Progress	Step 6: Execute Base Agreements with ~65 CBOs.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 7: Care Models Committee, including CBO representation, will define key measures for early implementation activities.	In Progress	Step 7: Care Models Committee, including CBO representation, will define key measures for early implementation activities.	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8: Meet with select CBOs in series of meetings to understand the full range of programs in which organizations may participate in OneCity Health DSRIP programs.	In Progress	Step 8: Meet with select CBOs in series of meetings to understand the full range of programs in which organizations may participate in OneCity Health DSRIP programs.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 9: Educate CBOs about Patient Activation Measure tool, inventory existing patient activation resources, and develop training and implementation plan for both technology and patient coaching.	In Progress	Step 9: Educate CBOs about Patient Activation Measure tool, inventory existing patient activation resources, and develop training and implementation plan for both technology and patient coaching.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

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

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize governance structure and sub-committee structure	nholder9	Rosters	52_MDL0203_1_3_20160126142558_OneCity_Health_Governance_Committee_Members_DY1_Q3.xlsx	OneCity Health Governance Committee Members	01/26/2016 02:25 PM
	nholder9	Meeting Materials	52_MDL0203_1_3_20160126142448_OneCity_Health_Governance_Committee_Meetings_DY1_Q3.xlsx	OneCity Health Governance Committee Meetings: Highlighted meetings took place in DY1 Q3.	01/26/2016 02:24 PM
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	cc607506	Other	52_MDL0203_1_3_20160201101238_OneCity_Health_Clinical_Recommendations_for_Review.pdf	OneCity Health Clinical Leadership Team - Recommendations	02/01/2016 10:12 AM
	cc607506	Other	52_MDL0203_1_3_20160201101015_OneCity_Health_Clinical_Leadership_Team_Workshop_Notes_v2.pdf	OneCity Health Clinical Leadership Team Workshop Notes	02/01/2016 10:10 AM
	nholder9	Other	52_MDL0203_1_3_20160126143701_OneCity_Health_Care_Models_Committee_Organizational_Chart.pdf	OneCity Health Care Models Committee Organizational Chart	01/26/2016 02:37 PM
	nholder9	Meeting Materials	52_MDL0203_1_3_20160126143605_OneCity_Health_Care_Models_Committee_Meeting_Schedule.xlsx	OneCity Health Care Models Committee Meeting Schedule	01/26/2016 02:36 PM

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
	nholder9	Rosters	52_MDL0203_1_3_20160126143209_OneCity_Health_Clinical_Governance_Committee.xlsx	OneCity Health Clinical Governance Committee Members	01/26/2016 02:32 PM
	nholder9	Documentation/Certification	52_MDL0203_1_3_20160126143018_OneCity_Health_Committee_Charters.pdf	Please see pages 6-7 for the Care Models Committee charter.	01/26/2016 02:30 PM
Establish governance structure reporting and monitoring processes	cc607506	Other	52_MDL0203_1_3_20160201102343_OneCity_Health_Governance_Reporting_and_Monitoring_Processes.pdf	OneCity Health Governance Reporting and Monitoring Processes	02/01/2016 10:23 AM
	cc607506	Templates	52_MDL0203_1_3_20160201102219_OneCity_Health_Implementation_Status_Report_Template.pdf	OneCity Health Implementation Status Report Template	02/01/2016 10:22 AM
	nholder9	Meeting Materials	52_MDL0203_1_3_20160126144733_20151215_OneCity_Health_Executive_Committee_Minutes_Vf.pdf	Please see agenda item #4, decision item #1 for the Executive Committee's approval.	01/26/2016 02:47 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize governance structure and sub-committee structure	The organization charts for the OneCity Health PPS have remained the same. Please see the attached documents for updates to our governance committee members and governance committee meetings. Please note that highlighted meetings on the meeting template took place in DY1 Q3.
Establish a clinical governance structure, including clinical quality committees for each DSRIP project	The OneCity Health Care Models Committee serves as the core clinical governance and clinical quality oversight body for the PPS. It is chaired by Dr. Joseph Masci, Director of Medicine at Elmhurst Hospital, and staffed by the OneCity Health Chief Clinical Officer, Dr. Anna Flattau. The scope and expertise of this committee encompasses all PPS projects, and the Committee forms ad-hoc workgroups as needed to conduct more detailed or project-specific work. Given the degree of overlap across OneCity Health's DSRIP projects and need for seamless integration across projects within any given care setting, OneCity Health seeks to mirror this integrated approach in its governance structure. As such, there are no permanent sub-committees set up under the OneCity Health Care Models Committee on a project-specific level. The Care Models Committee may create such committees as the need arises during the program implementation process. During DY1 Q1, OneCity Health Services convened ad-hoc Clinical Leadership Teams (CLT) for each project—groups of interdisciplinary leaders from across NYC Health and Hospitals and other partner organizations with clinical and operational subject matter expertise relevant to DSRIP projects. The CLTs were asked to make recommendations on initial clinical and operational protocols that should be standardized across the PPS. The topics were identified through planning and expert interviews conducted in advance of a two-day CLT workshop in April 2015. In order to further inform CLT discussions and recommendations, literature reviews were conducted on relevant clinical and operational topics. The evidence base resulting from the literature reviews were distributed to CLT members in advance of the workshops. These initial recommendations were consolidated into a set of clinical evidence-based approaches for program implementation and distributed for feedback to the PPS Project Advisory Committee (PAC) as well as the PPS Care Models Committee. As design and implementation of DSRIP-related work progress, OneCity

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	Health Services will work with the Care Models Committee, convening ad-hoc sub-workgroups as needed, to further refine these standards and tailor them to hub-specific needs through the hub-based clinical and operational planning process.
Finalize bylaws and policies or Committee Guidelines where applicable	There are no changes to report in regards to this milestone.
Establish governance structure reporting and monitoring processes	The Guidelines for Governance Reporting and Monitoring Processes establishes the processes, frequency and mechanisms through which OneCity Health's Executive Committee and other PPS governance committees, as appropriate, generally intend to conduct oversight and monitoring related to the implementation and performance of DSRIP initiatives. Both the guidelines and the reporting template were approved by the Executive Committee on December 15th, 2015. Please see "20151215 OneCity Health Executive Committee Minutes Vf" agenda item #4, decision item #1 for the Executive Committee's approval.
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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

No Records Found

New York City Health and Hospitals Corporation (PPS ID:52)

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.

Risk: Development and negotiation of the Base Agreement among the partners will likely present challenges, given variability in partner type, size, interests, capabilities and limitations.
Mitigation: We intend to mitigate this risk through the review process we have established. The planned review of the Base Agreement with partners' legal counsel will be transparent and will aim to reach mutually agreeable terms among all partners.

Risk: In addition, time constraints and other day-to-day obligations of governance committee members will pose a risk to the level of meaningful and productive engagement required to ensure a strong and effective governance structure.
Mitigation: This risk will be mitigated by support from the PPS Central Services Organization (CSO) in preparing meeting materials, establishing clear expectations among committee members around advanced meeting preparation, attendance, and active committee involvement. OneCity Health recognizes that committee members have significant obligations to their organizations outside of the PPS and will aim to be respectful of their time commitments.

Risk: As a City-wide PPS, we share partners with several other PPSs. For partners affiliated with multiple PPSs, ensuring that Governance and reporting processes do not present undue burden on these partners will pose a challenge.
Mitigation: We will address this risk by actively coordinating with other PPSs and aligning reporting processes and requests where possible.

IPQR Module 2.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The ability to develop the project schedules that are part of the partnership agreements with CBOs will depend on the development of Clinical Operational Plans which will detail partner obligations for each DSRIP project. Creation of the budgets for each partner's involvement in a particular project is dependent upon outputs of the Finance workstream, which will include projected PPS revenue, project budgets, and funds flow projections. In addition, the establishment of robust Performance Reporting/Management systems and capabilities will be critical to effectively monitoring partner performance against agreed-upon targets; these will in turn depend on the successful implementation of Reporting and Analytics IT infrastructure.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
PPS Governance Leadership	OneCity Health PPS Executive Committee: Ross Wilson, MD, Chair	Review and approve Governance Charters, Clinical Guidelines, Base Agreement and Project Schedules and budgets. Develop contracting priority order.
Lead Applicant/Entity	HHC	Review and approve Governance Charters.
Legal review	Lead Partner (HHC) Legal: Salvatore Russo, Esq, Senior Vice President and General Counsel, HHC	Review Governance Charters and Base Agreement.
Compliance	HHC Chief Compliance Officer: Wayne McNulty	Review PPS compliance plan.
PPS Clinical Governance Leadership	Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review and recommend clinical guidelines and provide quality oversight.
PPS Clinical Leadership	PPS Chief Clinical Officer: Anna Flattau, MD	Provide quality oversight.
Support infrastructure	PPS Central Services Organization- OneCity Health Services: Christina Jenkins, MD, CEO; Anna Flattau, MD, Chief Clinical Officer; Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manattan Hub Executive Director TBD; Hub Program Managers: Caroline Cross (Manhattan); Rachael Steimnitz (Brooklyn); Erfan Karim (Queens); Lindsay Donald (Bronx)	Support development of clinical guidelines, reporting process, partner oversight process, and policies and procedures.

New York City Health and Hospitals Corporation (PPS ID:52)

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		
Providers	PPS Partners	Committee membership, including the Project Advisory Committee
Community Based Organizations (CBOs)	PPS Partners	Committee membership, including the Project Advisory Committee
Labor Unions	PPS Partners	Committee membership, including the Project Advisory Committee
Government agencies	PPS Partners	Committee membership, including the Project Advisory Committee
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide Reporting standards
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide Reporting standards
NYC Department of Education	Government agency stakeholder	Coordination on Community and Stakeholder Engagement Strategy
City University of New York (CUNY)	Educational institution stakeholder	Coordination on Community and Stakeholder Engagement Strategy
State University of New York (SUNY)	Educational institution stakeholder	Coordination on Community and Stakeholder Engagement Strategy

New York City Health and Hospitals Corporation (PPS ID:52)

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.

Timely, accurate, and comprehensive quality and performance reporting will be critical to inform effective and transparent governance processes and decision-making. Shared IT infrastructure enabled by cross-PPS connectivity is required to produce the underlying data for a PPS-wide performance management and reporting process. Given the City-wide scope of the OneCity Health PPS, this connectivity is dependent on enabling successful connectivity between our partners with multiple RHIOs across all boroughs, and among the RHIOs themselves.

Developing the electronic governance portal will enable all PPS partners to access relevant governance materials which will improve engagement in PPS activities.

IPQR Module 2.8 - Progress Reporting

Instructions :

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

We define success as the achievement of robust, effective, and transparent PPS governance at both a City-wide and Hub level. Fulfillment of the milestones described above will reflect our progress in building the infrastructure required to support this multi-tiered governance. Success will be measured by (1) the occurrence of meetings of the Executive Committee and Subcommittees at a frequency in accordance with the applicable charter, (2) implementation of PPS policies and procedures, (3) execution of the Base Agreement and project schedules by HHC and partners (including CBOs), and (4) performance by OneCity Health and partners (including CBOs) of obligations against the Base Agreement.

IPQR Module 2.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 03 – Financial Stability

IPQR Module 3.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Finalize PPS finance structure, including reporting structure	Completed	This milestone must be completed by 12/31/2015. PPS finance structure chart / document, signed off by PPS Board.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1: Finalize appointment of Business Operations & Information Technology Subcommittee membership.	Completed	Step 1: Finalize appointment of Business Operations & Information Technology Subcommittee membership.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Obtain Executive Committee sign off of PPS finance structure, policies and procedures.	Completed	Step 2: Obtain Executive Committee sign off of PPS finance structure, policies and procedures.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Identify and implement required PPS financial controls.	Completed	Step 3: Identify and implement required PPS financial controls.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 4: Convene regular Business Operations & Information Technology Subcommittee meetings.	Completed	Step 4: Convene regular Business Operations & Information Technology Subcommittee meetings.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 5: Document Business Operations & Information Technology Subcommittee actions and minutes and provide regular reports to PPS Executive Committee.	Completed	Step 5: Document Business Operations & Information Technology Subcommittee actions and minutes and provide regular reports to PPS Executive Committee.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	In Progress	This milestone must be completed by 3/31/2016. Network financial health current state assessment (to be performed at least annually). The PPS must: - identify those providers in their network that are financially fragile, including those that have qualified as IAAF providers;	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 their approach for monitoring those financially fragile providers, which must include an analysis of provider performance on the following financial indicators: days cash on hand, debt ratio, operating margin and current ratio; -- include any additional financial indicators that they deem necessary for monitoring the financial sustainability of their network providers							
Task Step 1: Assess financial impact resulting from implementation of DSRIP projects, including expected impact on provider cost, patient volumes, revenue, ALOS, and other metrics based upon project goals and provider participation.	Completed	Step 1: Assess financial impact resulting from implementation of DSRIP projects, including expected impact on provider cost, patient volumes, revenue, ALOS, and other metrics based upon project goals and provider participation.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Conduct financial health current state assessment of new PPS partners by utilizing assessment tool developed during the DSRIP planning phase.	Completed	Step 2: Conduct financial health current state assessment of new PPS partners by utilizing assessment tool developed during the DSRIP planning phase.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Review and obtain approval of DSRIP impact analysis from Business Operations & Information Technology Subcommittee and PPS Executive Committee as basis for Sustainability and applicable portions of the PPS Flow of Funds plan.	In Progress	Step 3: Review and obtain approval of DSRIP impact analysis from Business Operations & Information Technology Subcommittee and PPS Executive Committee as basis for Sustainability and applicable portions of the PPS Flow of Funds plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Review all results of financial health current state assessment and, if applicable, identify financially fragile partners.	In Progress	Step 4: Review all results of financial health current state assessment and, if applicable, identify financially fragile partners.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Develop process for monitoring financially fragile partners including the involvement of the Business Operations & Information Technology Subcommittee.	In Progress	Step 5: Develop process for monitoring financially fragile partners including the involvement of the Business Operations & Information Technology Subcommittee.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 6: Review and revise financial health	In Progress	Step 6: Review and revise financial health current state assessment tool as needed to capture key financial health,	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
current state assessment tool as needed to capture key financial health, sustainability indicators, and financial impact of DSRIP projects, conduct assessments on an annual basis.		sustainability indicators, and financial impact of DSRIP projects, conduct assessments on an annual basis.							
Task Step 7: Develop Financial Stability Plan – including metrics and ongoing monitoring – and obtain approval from Business Operations & Information Technology Subcommittee.	In Progress	Step 7: Develop Financial Stability Plan – including metrics and ongoing monitoring – and obtain approval from Business Operations & Information Technology Subcommittee.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #3 Finalize Compliance Plan consistent with New York State Social Services Law 363-d	Completed	This milestone must be completed by 12/31/2015. Finalized Compliance Plan (for PPS Lead).	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1: Onboard Senior Executive Compliance Officer to provide executive compliance oversight and management of DSRIP-related compliance activities and DSRIP Senior Compliance Officer to focus on DSRIP compliance and privacy-related activities.	Completed	Step 1: Onboard Senior Executive Compliance Officer to provide executive compliance oversight and management of DSRIP-related compliance activities and DSRIP Senior Compliance Officer to focus on DSRIP compliance and privacy-related activities.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Operationalize audit committee structure at HHC and PPS levels.	Completed	Step 2: Operationalize audit committee structure at HHC and PPS levels.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Conduct DSRIP compliance risk assessment and identification as part of HHC corporate-wide assessment of threats, risks, vulnerabilities, and effectiveness of internal controls in an effort to carry out risk identification requirements under 18 NYCRR part 521 and to score, prioritize, evaluate, mitigate, and monitor corporate-wide risks.	Completed	Step 3: Conduct DSRIP compliance risk assessment and identification as part of HHC corporate-wide assessment of threats, risks, vulnerabilities, and effectiveness of internal controls in an effort to carry out risk identification requirements under 18 NYCRR part 521 and to score, prioritize, evaluate, mitigate, and monitor corporate-wide risks.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Create DSRIP Compliance Plan to reflect regulatory compliance expectations related to the use and distribution of DSRIP funds, standards of conduct, receipt of complaints/non-retaliation	Completed	Step 4: Create DSRIP Compliance Plan to reflect regulatory compliance expectations related to the use and distribution of DSRIP funds, standards of conduct, receipt of complaints/non-retaliation policies, monitoring procedures,	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
policies, monitoring procedures, and education/training on DSRIP-related compliance expectations.		and education/training on DSRIP-related compliance expectations.							
Task Step 5: Present PPS Compliance plan to Executive Committee for approval; publish Plan and distribute to PPS partners.	Completed	Step 5: Present PPS Compliance plan to Executive Committee for approval; publish Plan and distribute to PPS partners.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #4 Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	In Progress	This milestone must be completed by 3/31/2016. Value-based payment plan, signed off by PPS board	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	YES
Task Step 1: Review final State Medicaid value-based payment roadmap upon release.	Completed	Step 1: Review final State Medicaid value-based payment roadmap upon release.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Adapt existing HHC Medicaid value-based payment reporting structure and capture partner value-based data.	In Progress	Step 2: Adapt existing HHC Medicaid value-based payment reporting structure and capture partner value-based data.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Assess the current state of Medicaid value-based payment arrangements and associated revenue across all PPS partners. (To be completed/updated on an annual basis.)	In Progress	Step 3: Assess the current state of Medicaid value-based payment arrangements and associated revenue across all PPS partners. (To be completed/updated on an annual basis.)	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Develop preferred compensation and Medicaid MCO strategy framework through PPS sub-committees.	In Progress	Step 4: Develop preferred compensation and Medicaid MCO strategy framework through PPS sub-committees.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Present assessment to PPS Business Operations and IT Subcommittee and to PPS Executive Committee for review and approval.	In Progress	Step 5: Present assessment to PPS Business Operations and IT Subcommittee and to PPS Executive Committee for review and approval.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	In Progress	This milestone must be completed by 12/31/2016. Value-based payment plan, signed off by PPS board	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3	YES
Task	Completed	Step 1: Review final State Medicaid value-based payment	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 1: Review final State Medicaid value-based payment roadmap upon release.		roadmap upon release.							
Task Step 2: Review baseline assessment of PPS partners' Medicaid value-based payment revenue to inform development of PPS value-based payment plan.	In Progress	Step 2: Review baseline assessment of PPS partners' Medicaid value-based payment revenue to inform development of PPS value-based payment plan.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Conduct gap assessment between current volume of Medicaid value-based revenue across the PPS network and State target of 90%.	In Progress	Step 3: Conduct gap assessment between current volume of Medicaid value-based revenue across the PPS network and State target of 90%.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 4: Establish annual targets for volume of Medicaid value-based revenue across the PPS network. (To be completed on an ongoing basis.)	In Progress	Step 4: Establish annual targets for volume of Medicaid value-based revenue across the PPS network. (To be completed on an ongoing basis.)	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Finalize PPS Medicaid value-based payment plan and present to Executive Committee for approval. Provide quarterly updates to Executive Committee on progress toward value-based payment and revise PPS plan as needed.	In Progress	Step 5: Finalize PPS Medicaid value-based payment plan and present to Executive Committee for approval. Provide quarterly updates to Executive Committee on progress toward value-based payment and revise PPS plan as needed.	10/01/2016	12/31/2016	10/01/2016	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 to be in 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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	nholder9	Meeting Materials	52_MDL0303_1_3_20160127100107_OneCity_Health_Business_Operations_and_It_Meetings.xlsx	OneCity Health Business Operations and It Meetings	01/27/2016 10:01 AM
	nholder9	Documentation/Certification	52_MDL0303_1_3_20160125174001_OneCity_Health_Committee_Charters.pdf	See pages 8-10 for the Business Operations and IT Subcommittee charter.	01/25/2016 05:40 PM
	nholder9	Meeting Materials	52_MDL0303_1_3_20160125173800_20150701_OneCity_Health_Executive_Committee_Minutes.pdf	See "Decisions" under Agenda Item #3 for Executive Committee approval of the Business Operations and IT Subcommittee charter.	01/25/2016 05:38 PM
	nholder9	Documentation/Certification	52_MDL0303_1_3_20160125173601_OneCity_Health_Financial_Structure.pdf	This document outlines the financial structure of the OneCity Health PPS.	01/25/2016 05:36 PM
Finalize Compliance Plan consistent with New York State Social Services Law 363-d	nholder9	Documentation/Certification	52_MDL0303_1_3_20160125174626_NYS_OMIG_Compliance_Certification_SSL.pdf	This document verifies OneCity Health's NYS OMIG Compliance Certifiation via our PPS-lead, NYC Health and Hospitals.	01/25/2016 05:46 PM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize PPS finance structure, including reporting structure	The OneCity Health Business Operations and IT Committee has the responsibility of recommending budgets and the distribution of DSRIP funds, subject to approval by the Executive Committee and NYC Health and Hospitals. The PPS Executive Committee most recently approved the Business Operations and IT Committee charter on July 1, 2015. The committee has been appointed with initial membership and held its inaugural meeting on August 3, 2015. The OneCity Health Master Services Agreement (MSA) outlines at a high-level the process for distributing DSRIP payments within the PPS network. The PPS Executive Committee approved the MSA in July 2015. As with other centralized functions, the OneCity Health PPS will leverage existing finance infrastructure within its fiduciary lead, NYC Health + Hospitals, and rely on the finance structure, policies/procedures, and financial controls of its fiduciary lead. Initially, as OneCity Health Services established its finance roles, consultants worked with NYC Health + Hospitals to support these functions. Over time, we anticipate PPS-specific processes will be developed as needed, with oversight from the PPS governance structure.
Perform network financial health current state assessment and develop financial sustainability strategy to address key issues.	
Finalize Compliance Plan consistent with New York State	As with other centralized functions, OneCity Health PPS will leverage existing centralized infrastructure within its fiduciary lead, the NYC Health + Hospitals, when

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Social Services Law 363-d	appropriate. The OneCity Health Master Services Agreement (MSA), which establishes official partnerships within the PPS network, states that our partners will adhere to the compliance program developed by NYC Health + Hospitals. On December 29, 2015, a compliance program, consistent with NYS Social Services Law 363-d was certified. The NYC Health + Hospitals Compliance Plan along with the NYC Health + Hospitals Guide to Compliance include sections related to OneCity Health's DSRIP work. The compliance program addresses all risks, which are separated into four phases: (i) the assessment phase: establishing what our goals are with regard to each risk and highlighting the regulatory, industry, or best practice standard that we want to achieve; (ii) the mitigation phase: implementing a plan to mitigate risk results derived from the assessment phase; (iii) the monitoring phase: monitoring and auditing to ensure compliance post mitigation; and (iv) post cycle review phase: setting a date where we reassess to ensure continued compliance. In addition, NYC Health + Hospitals has contracted with a vendor to provide a compliance helpline to address NYC Health + Hospitals compliance complaints as well as specific DSRIP concerns.
Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider-types and functions, and MCO strategy.	
Finalize a plan towards achieving 90% value-based payments across network by year 5 of the waiver at the latest	
Put in place Level 1 VBP arrangement for PCMH/APC care and one other care bundle or subpopulation	
Contract 50% of care-costs through Level 1 VBPs, and >= 30% of these costs through Level 2 VBPs or higher	
>=90% of total MCO-PPS payments (in terms of total dollars) captured in at least Level 1 VBPs, and >= 70% of total costs captured in VBPs has to be in Level 2 VBPs or higher	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

• Risk: Insufficient provider engagement
Mitigation: The PPS must meaningfully engage with PPS partners and communicate a set of PPS partner/provider funding schedules at the outset of DSRIP implementation to ensure that partners and their providers understand the process and project milestones tied to receiving payment from the PPS. In addition, as the PPS begins to engage partners around the Master Services Agreement and clinical operational planning, it will need to be transparent on the budgeting and payment processes, and educate partners on the ties to funds flow and, ultimately, funding schedules.

•Risk: Availability of DSRIP waiver funds and uncertainty around the ability of the PPS to achieve and draw down incentive payments both present risks. The PPS must successfully achieve and report on State-established milestones and metrics to draw down incentive payments and subsequently distribute funds to its partners.
Mitigation: The PPS has and will continue to engage in a thoughtful planning process to ensure it is able to achieve DSRIP milestones and metrics in a timely manner and to the best of its ability and will design the budgeting process with flexibility to allow for scenarios in which the PPS may miss certain targets.

• Risk: Timing of DSRIP waiver funds: Once the PPS has demonstrated successful achievement of reporting and/or performance metrics, incentive payments will not be made for 90-120 days, leaving a potential gap in funding available to support DSRIP projects.
Mitigation: The PPS must actively track payments received and expenditures incurred to minimize the periods of low cash holdings. In addition, judicious usage of the PPS Contingency Fund will help to alleviate periods of potential low cash holdings.

• Risk: Alignment of PPS partners with Medicaid value-based payment models: Although the PPS currently has the majority of its Medicaid Managed Care lives in global risk contracts that reward performance consistent with DSRIP, the continued transition to value-based payment across the PPS will require the engagement with PPS partners and Medicaid managed care organizations (MCOs) to align contracting with value-based payment.
Mitigation: As the PPS lead, HHC expects to leverage its considerable experience in managing value-based payment models and extend value-based payment arrangements to other PPS partners.

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.)

New York City Health and Hospitals Corporation (PPS ID:52)

• Performance reporting: Identify point-of-contact in each partner organization for finance-related matters (e.g., reporting and policies/procedures); base partner reporting requirements on DSRIP reporting milestones/metrics.

• IT: The PPS IT systems must support population health management to enable partners to improve patient outcomes that will drive the transition to value-based payment with Medicaid MCOs and other payers.

• Practitioner Engagement: The PPS must effectively engage and educate physicians and other providers in the evidence-based protocols and requirements that will drive performance and contracting.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
PPS Governance Leadership	PPS Executive Committee: Ross Wilson, MD, Chair	Review and approve recommendations from Business Operations and IT Subcommittee
PPS Governance Entity	Business Operations and IT Subcommittee: Chair TBD; staffed by Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation, and OneCity Health Services Finance Director	Review and recommend network financial health current state assessment and value-based payment plan
Compliance Oversight	HHC Office of Corporate Compliance and Chief Compliance Officer: Wayne McNulty	Establish and maintain an effective compliance program as required by, and in accordance with, New York Social Services Law 363-d and its implementing regulations found at 18 NYCRR Part 521
Expense Oversight	PPS Comptroller: Julian John, HHC Corporate Comptroller	Review and manage PPS expenditures
Compliance Lead	Chief Compliance Officer: Wayne McNulty	Provide executive compliance oversight and management of DSRIP-related compliance plan and activities
Audit function	Internal Auditor	Review PPS budget and funds flow
Finance Lead	PPS Finance Director: permanent Director being recruited; interim support from HHC Corporate Finance	Prepare PPS budgets and forecasts
HHC Corporate Finance	Marlene Zurack, HHC Corporate Chief Financial Officer; Laura Free, AVP Managed Care Finance; Krista Olson, AVP Corporate Budget Director; Linda Dehart, AVP Corporate Reimbursement	Support PPS Finance operations, financials sustainability planning, and value-based contracting strategy

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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		
PPS Partners	Performing providers	Responsible for performance on program metrics, participation in clinical project implementation, accountability for use of funds
HHC and other Partner Finance Organizations	Finance support	Collaborate with PPS to participate in network financial health assessment and alignment of PPS network with value-based purchasing models
External Stakeholders		
MetroPlus, HealthFirst	Partner in development of value-based payment arrangements	Collaborate with PPS and providers to develop value-based payment arrangements
Other Managed Care Organizations	Partner in development of value-based payment arrangements	Collaborate with PPS and providers to develop value-based payment arrangements

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

A shared IT infrastructure across the PPS will prove instrumental in allowing the PPS to maintain a real-time assessment of performance across partners, which will be critical to success as PPS partners transition to value-based payment. The PPS is establishing a centralized performance management analytics and reporting environment to store normalized claim, clinical and other patient-level data in HHC's Business Intelligence/Enterprise Data Warehouse based on the IBM Provider Data Model. We expect that the dashboards produced using this system will help drive improved outcomes and allow the PPS to monitor performance against key metrics by benchmarking our providers against standardized NQF quality measures to address gaps in care for chronic diseases.

IPQR Module 3.8 - Progress Reporting

Instructions :

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

The financial sustainability workstream will be considered successful based on the demonstrated ability to:

•Identify and monitor the PPS partner organizations that are or will become financially fragile during the course of the DSRIP period

•Seamlessly implement and adhere to financial controls and the PPS compliance plan

•Establish and execute the PPS' plans to transition to the targeted volume of Medicaid value-based payment revenues.

IPQR Module 3.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	YES
Task Step 1: Based on a review of the Community Needs Assessment, claims data, and other data available from our PPS partners, determine priority groups experiencing health disparities and needs for cultural competency and health literacy strategy.	Completed	Step 1: Based on a review of the Community Needs Assessment, claims data, and other data available from our PPS partners, determine priority groups experiencing health disparities and needs for cultural competency and health literacy strategy.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 2: Identify areas of demonstrated PPS strength among HHC facilities and other PPS partners in addressing cultural competency,	Completed	Step 2: Identify areas of demonstrated PPS strength among HHC facilities and other PPS partners in addressing cultural competency, health literacy and health disparities; identify key	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	

New York City Health and Hospitals Corporation (PPS ID:52)

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 and health disparities; identify key gaps as well.		gaps as well.							
Task Step 3: Develop a cultural competency and health literacy strategy document, which includes the following minimum components and takes into consideration unique attributes of each PPS Hub: (1) key factors to improve access to quality primary, behavioral health, and preventive care; (2) plans for two-way communication with the population and community groups through specific community forums; (3) assessments and tools to assist patients with self-management (in concert with PPS clinical planning around patient self-management); and, (4) community-based interventions to reduce health disparities and improve outcomes.	Completed	Step 3: Develop a cultural competency and health literacy strategy document, which includes the following minimum components and takes into consideration unique attributes of each PPS Hub: (1) key factors to improve access to quality primary, behavioral health, and preventive care; (2) plans for two-way communication with the population and community groups through specific community forums; (3) assessments and tools to assist patients with self-management (in concert with PPS clinical planning around patient self-management); and, (4) community-based interventions to reduce health disparities and improve outcomes.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Review and consensus-driven recommendation of Strategy document by PPS Care Models Subcommittee and Stakeholder & Patient Engagement Subcommittees.	On Hold	Step 4: Review and consensus-driven recommendation of Strategy document by PPS Care Models Subcommittee and Stakeholder & Patient Engagement Subcommittees.	10/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 5: Strategy document reviewed and approved by Executive Committee.	Completed	Step 5: Strategy document reviewed and approved by Executive Committee.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 4: Review and consensus-driven recommendation of Strategy document by PPS Stakeholder & Patient Engagement Subcommittee.	Completed	Step 4: Review and consensus-driven recommendation of Strategy document by PPS Stakeholder & Patient Engagement Subcommittee.			10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Milestone #2 Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	In Progress	This milestone must be completed by 6/30/2016. Cultural competency training strategy, signed off by PPS Board. The strategy should include: -- Training plans for clinicians, focused on available evidence-based research addressing health disparities for particular groups identified in your cultural competency strategy -- Training plans for other segments of your workforce (and	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		others as appropriate) regarding specific population needs and effective patient engagement approaches							
Task Step 1: Determine approach to developing PPS-wide training strategy, including identifying contractors (as relevant) and developing high-level requirements for training needs, taking into account unique local training needs within each of OneCity Health's hubs.	Completed	Step 1: Determine approach to developing PPS-wide training strategy, including identifying contractors (as relevant) and developing high-level requirements for training needs, taking into account unique local training needs within each of OneCity Health's hubs.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: In the context of overall DSRIP-related training, develop specific requirements for training plan for clinicians, focused on available evidence-based research addressing health disparities for groups identified in the OneCity Health cultural competency strategy.	In Progress	Step 2: In the context of overall DSRIP-related training, develop specific requirements for training plan for clinicians, focused on available evidence-based research addressing health disparities for groups identified in the OneCity Health cultural competency strategy.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: In the context of overall DSRIP-related training, develop specific requirements for training plans for other segments of the workforce regarding specific population needs and effective patient engagement approaches.	In Progress	Step 3: In the context of overall DSRIP-related training, develop specific requirements for training plans for other segments of the workforce regarding specific population needs and effective patient engagement approaches.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Finalize approach to implementing cultural competency training, including contracting (as applicable).	In Progress	Step 4: Finalize approach to implementing cultural competency training, including contracting (as applicable).	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: OneCity Health Executive Committee reviews and approves cultural competency training strategy document.	In Progress	Step 5: OneCity Health Executive Committee reviews and approves cultural competency training strategy document.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Finalize cultural competency / health literacy strategy.	jenkinsc	Other	52_MDL0403_1_3_20160316125016_20160316_OneCity_Health_Cultural_Competency_Health_Literacy_Appendix_vF.docx	Cultural Competency Health Literacy Appendix	03/16/2016 12:50 PM
	cc607506	Documentation/Certification	52_MDL0403_1_3_20160128171906_20151231_OneCity_Health_CC_HL_Strategic_Plan_vFINAL.pdf	Cultural Competency & Health Literacy strategic plan	01/28/2016 05:19 PM
	nholder9	Meeting Materials	52_MDL0403_1_3_20160128100044_Cultural_Competency_&_Health_Literacy_Meeting_Schedule.xlsx	Cultural Competency & Health Literacy Meeting Schedule	01/28/2016 10:00 AM
	nholder9	Meeting Materials	52_MDL0403_1_3_20160127105820_20151215_OneCity_Health_Stakeholder_and_Patient_Engagement_Committee_MeetingMinutes_vf.pdf	See agenda item #2.	01/27/2016 10:58 AM
	nholder9	Meeting Materials	52_MDL0403_1_3_20160127105717_20151215_OneCity_Health_Executive_Committee_Minutes_Vf.pdf	See agenda item #4 , decision #2 with the Executive Committee's approval.	01/27/2016 10:57 AM

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Finalize cultural competency / health literacy strategy.	OneCity Health"s Cultural Competency and Health Literacy Strategy provides a framework detailing how our PPS network will improve cultural competency and health literacy by building organizational capacity across the PPS through leadership and workforce training, education and recruitment. The strategy was developed collaboratively with input from facilitated workgroups, which consisted of community partners, subject matter experts, and community members. This workgroup collaborated with NYC Health + Hospitals" cultural competency experts to discuss cultural competency work in progress as well as areas for improvement. Elements of the NYC Health + Hospitals Health Equity and Cultural Competency Strategy were used in the development of OneCity Health"s strategy. The strategy document was reviewed by the PPS's Stakeholder & Patient Engagement Committee and approved by the Executive Committee on December 15, 2015. Please see attached meeting minutes to verify the strategy's approval. An attachment was included on 3/16/16 in response to the IA's DY1 Q3 comments regarding Milestone #1.
Develop a training strategy focused on addressing the drivers of health disparities (beyond the availability of language-appropriate material).	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

Risk: We have identified a number of risks to implementation. First, the degree of cultural, ethnic and language diversity across our service area will challenge our PPS to meet the needs of all attributed patients. For example, the population of foreign born residents with low literacy rates ranges from 24.6% to 48% [being validated]. This will make prioritization of resources and training approaches more complex and resource intensive.
Mitigation: To mitigate this risk, we intend to work with partners with demonstrated expertise in meeting the needs of their respective communities. This work will include leveraging existing best practices to identify and meet the education and training needs across the PPS.

Risk: The second risk we have identified is the time needed to provide cultural competency and health literacy training to clinicians and staff. In addition to training on these topics, we expect to have a broad range of DSRIP-related training and educational needs, including needs around clinical guidelines and processes, operational workflows, PPS standards, data collection and monitoring, etc.
Mitigation: To address this risk, we intend to design and deploy a training strategy that identifies all the clinical and non-clinical training needs and includes a rational approach to delivering that training. As a result of the need to harmonize PPS-wide training efforts, cultural competency and health literacy training may be on a slightly less aggressive timeframe than it would otherwise be.

Risk: Finally, the City-wide scope of the OneCity Health PPS introduces a high degree of complexity and diversity in executing on an effective Cultural Competency/Health Literacy strategy, as patient and community needs/engagement will vary across boroughs and geographies.
Mitigation: OneCity Health's Hub-based structure will allow for this risk to be mitigated through Hub-based planning that takes into account the local network of established community-based organizations and local knowledge/expertise around patient engagement barriers and solutions.

IPQR Module 4.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

As described in Risks & Mitigation Strategies, the achievement of OneCity Health's cultural competency and health literacy strategies is dependent on developing the overall approach to PPS training and education and an overarching Practitioner Engagement strategy. In addition, because the strategy relies on a keen understanding of existing areas of expertise and available tools among partners, we must first complete a partner assessment process, which seeks to identify partner capabilities and capacity across a broad range of areas, including cultural competency. Finally, the ability of providers to meet the language needs of their patients will be dependent on the capability to know a patient's preferred language. As a result, OneCity Health will need systems to track and share this information with partners in the PPS.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Supporting the PPS governance Committees and Partners	OneCity Health Services: Christina Jenkins, MD, CEO	Working with PPS governance committees and partners to ensure the PPS meets DSRIP milestones.
Governance	Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review and recommend clinical processes for project implementation, including cultural competency/health literacy standards.
Governance	Patient & Stakeholder Engagement Subcommittee	Review and recommend strategy to engage patients and stakeholders, including cultural competency/health literacy standards.
Governance	OneCity Health Executive Committee: Ross Wilson, MD, Chair	Review recommendations from subcommittees.
PPS Cultural Competency Lead	Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Accountable for the development of cultural competency/health literacy standards

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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		
Project Advisory Committees	Total PPS and Hub-based PACs	Provide input and feedback into PPS cultural competency/health literacy initiatives
Providers	PPS Partners	Provide input and feedback into PPS cultural competency/health literacy initiatives
Community Based Organizations (CBOs)	PPS Partners	Provide input and feedback into PPS cultural competency/health literacy initiatives
Labor Unions	PPS Partners	Provide input and feedback into PPS cultural competency/health literacy training plans
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide CC/HL approaches
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide CC/HL approaches

New York City Health and Hospitals Corporation (PPS ID:52)

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.

As described in Major Dependencies on Other Workstreams, there are a number of areas where IT capabilities will enable OneCity Health to address cultural competency and health literacy issues. First, providers will need to meet the language needs of their patients. This may include access to interpreter services, providing educational materials that have been translated into another language, or connecting patients to a support group that meets a patient's cultural and ethnic preferences. To respond to these requirements, OneCity Health will need to identify and track the language preferences of its attributed patients and ensure this information is accessible to PPS clinicians and staff at the point of care. OneCity Health will also need to determine threshold languages for translation needs and make translated materials available across the PPS. Finally, OneCity Health will need to track and make available PPS resources (e.g., in-language support groups) so that patients can be easily connected to community supports that improve self-management and self-efficacy efforts.

In addition, the tools and approaches adopted by the PPS to engage patients in self-management and to promote self-efficacy will need to be tailored to the culturally-specific strategies unique to each community. Flexible IT platforms to house and deploy these tools will be critical to ensuring that patient engagement strategies are responsive to these local needs.

Finally, technology support will be required for tracking of training program delivery and effectiveness.

IPQR Module 4.8 - Progress Reporting

Instructions :

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

We define successful design and deployment of a PPS Cultural Competency/Health Literacy strategy as the effective incorporation of the unique cultural and health literacy needs and barriers of our patient populations into the process by which our clinical guidelines, operational processes, and training programs are developed and implemented. Fulfillment of the milestones for this workstream will reflect our progress in building the infrastructure required to support this strategy. Success will be measured by the degree to which key health disparity and patient engagement activation are improved across the PPS.

IPQR Module 4.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section 05 – IT Systems and Processes

IPQR Module 5.1 - Prescribed Milestones

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Milestone #1 Perform current state assessment of IT capabilities across network, identifying any critical gaps, including readiness for data sharing and the implementation of interoperable IT platform(s).	In Progress	Detailed IT current state assessment. Relevant QEs (RHIOs/HIEs) should be involved in performing this assessment.	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: Central Services Organization to organize, review and assess partner IT readiness assessment data collected via the Partner Readiness Assessment Tool, populate interim partner database, and conduct further data collection via interviews or site visits to fill gaps.	Completed	Step 1: Central Services Organization to organize, review and assess partner IT readiness assessment data collected via the Partner Readiness Assessment Tool, populate interim partner database, and conduct further data collection via interviews or site visits to fill gaps.	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Review partner data to assess current state of data sharing readiness in terms of Meaningful Use Certified EHRs and connectivity to the QEs (HIE). Vet key results with select partners and PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	In Progress	Step 2: Review partner data to assess current state of data sharing readiness in terms of Meaningful Use Certified EHRs and connectivity to the QEs (HIE). Vet key results with select partners and PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Complete IT current state assessment supporting documentation for central PPS and partner IT.	In Progress	Step 3: Complete IT current state assessment supporting documentation for central PPS and partner IT.	10/01/2015	03/31/2016	10/01/2015	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:	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		-- 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							
Task Step 1: Establish Business Operations & Information Technology Subcommittee, which includes representation across Partners.	Completed	Step 1: Establish Business Operations & Information Technology Subcommittee, which includes representation across Partners.	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1	
Task Step 2: Document Business Operations & Information Technology Subcommittee charter and processes.	Completed	Step 2: Document Business Operations & Information Technology Subcommittee charter and processes.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2	
Task Step 3: Develop communication, education and training plan related to IT Change Management.	In Progress	Step 3: Develop communication, education and training plan related to IT Change Management.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: Develop impact/risk assessment for IT change process.	In Progress	Step 4: Develop impact/risk assessment for IT change process.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Define workflows for authorizing and implementing IT changes.	In Progress	Step 5: Define workflows for authorizing and implementing IT changes.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
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	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
		all Medicaid providers within the PPS; contracts with all relevant CBOs including a BAA documenting the level of PHI to be shared and the purpose of this sharing).							
Task Step 1: Document clinical connectivity roadmap (QEs) and PPS partner strategy for exchanging clinical data set and obtain Business Operations & Information Technology Subcommittee approval.	In Progress	Step 1: Document clinical connectivity roadmap (QEs) and PPS partner strategy for exchanging clinical data set and obtain Business Operations & Information Technology Subcommittee approval.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.	In Progress	Step 2: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Establish and communicate connectivity priorities, and partner support resources, including training plan and/or third party assistance programs.	In Progress	Step 3: Establish and communicate connectivity priorities, and partner support resources, including training plan and/or third party assistance programs.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: Develop approach for tracking and reporting on changes to data sharing agreements.	In Progress	Step 4: Develop approach for tracking and reporting on changes to data sharing agreements.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
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	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: Validate/match attributed members against QE RHIO consents on file to inform engagement strategy/plan.	On Hold	Step 1: Validate/match attributed members against QE RHIO consents on file to inform engagement strategy/plan.	10/01/2015	12/31/2015	04/01/2015	03/31/2020	03/31/2020	DY5 Q4	
Task Step 2: Review current consent processes and lessons learned/challenges with QE.	Completed	Step 2: Review current consent processes and lessons learned/challenges with QE.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Develop recommendations for outreach to members to obtain consent and obtain Business Operations & Information Technology Subcommittee and Executive Committee	In Progress	Step 3: Develop recommendations for outreach to members to obtain consent and obtain Business Operations & Information Technology Subcommittee and Executive Committee approval, leveraging broader patient engagement strategy and emerging cultural competency strategy.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
approval, leveraging broader patient engagement strategy and emerging cultural competency strategy.									
Task Step 4: Develop approach for tracking and reporting on member engagement in QE.	In Progress	Step 4: Develop approach for tracking and reporting on member engagement in QE.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Milestone #5 Develop a data security and confidentiality plan.	In Progress	Data security and confidentiality plan, signed off by PPS Board, including: -- Analysis of information security risks and design of controls to mitigate risks -- Plans for ongoing security testing and controls to be rolled out throughout network.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	NO
Task Step 1: Analyze data security risks and design controls and strategy to mitigate risks.	Completed	Step 1: Analyze data security risks and design controls and strategy to mitigate risks.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Develop plan for ongoing security testing.	Completed	Step 2: Develop plan for ongoing security testing.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 3: Incorporate risk mitigation and security testing recommendations into data security and confidentiality plan and obtain Business Operations & Information Technology Subcommittee and Executive Committee approval.	In Progress	Step 3: Incorporate risk mitigation and security testing recommendations into data security and confidentiality plan and obtain Business Operations & Information Technology Subcommittee and Executive Committee approval.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Develop approach for tracking and reporting on implementation of plan.	In Progress	Step 4: Develop approach for tracking and reporting on implementation of plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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Delivery System Reform Incentive Payment Project

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date
Develop a data security and confidentiality plan.	nholder9	Other	52_MDL0503_1_3_20160314102514_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PS_Family)Updated_3-9-16.docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (PS Family)- Updated 3-9-16	03/14/2016 10:25 AM
	nholder9	Other	52_MDL0503_1_3_20160314102437_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(PE_Family)_Updated_3-9-16.docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (PE Family)- Updated 3-9-16	03/14/2016 10:24 AM
	nholder9	Other	52_MDL0503_1_3_20160314102341_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(IR_Family)_Updated_3-9-16.docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (IR Family)- Updated 3-9-16	03/14/2016 10:23 AM
	nholder9	Other	52_MDL0503_1_3_20160314102303_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AU_Family)_Updated_3-9-16.docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (AU Family)- Updated 3-9-16	03/14/2016 10:23 AM
	nholder9	Other	52_MDL0503_1_3_20160314102115_OHIP_DOS_System_Security_Plan_(SSP)_Moderate_Plus_Workbook_(AT_Family)_Updated_3-9-16.docx	OHIP DOS System Security Plan (SSP) Moderate Plus Workbook (AT Family)- Updated 3-9-16	03/14/2016 10:21 AM

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	The activities in this milestone require an actionable member roster for matching purposes. The OneCity Health PPS has been advised by the State that its rosters are being revised and that new rosters will not be available to the PPS until January 25th, 2016; therefore, the timing of this milestone is being shifted back until after the anticipated receipt of the roster.
Develop a data security and confidentiality plan.	

Milestone Review Status

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

NYS Confidentiality – High

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Risk: We anticipate reluctance on the part of some partners to agree to certain elements of IT governance and requirements, since it will require them to use IT systems and processes unfamiliar to them, some of which may duplicate systems and processes already in place within their own organizations.
Mitigation: We will educate partners on the need and justification for all requirements, processes and IT change management governance and incorporate provisions for complying with them into contractual agreements to eliminate ambiguity and clarify that compliance is contractually obligated.

Risk: Partners may be challenged—financially or otherwise— to comply with data sharing obligations, especially those who had not previously participated in data exchange or whose IT infrastructures may not meet certified EHR MU requirements.
Mitigation: Again, we will educate all partners on the importance of data sharing and incorporate data sharing agreements into their contracts.

Risk: Patient engagement in QEs, as measured by consent, is critical to achieving patient engagement speed and scale for 2.a.i and many other projects, since consent is required for data sharing and data sharing is integral to meeting the requirements of most projects.
Mitigation: We will work with the Bronx RHIO, Healthix and Interboro QEs to understand gaps in patient engagement, as measured by consent, and to implement targeted strategies for obtaining consent from more attributed patients.

IPQR Module 5.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The IT workstream is dependent on strategies and requirements developed in the Performance Reporting, Clinical Integration and Population Health Management workstreams primarily, and to a lesser extent in all other organizational workstreams to the extent they identify IT expectations (e.g., for a learning management system in the Workforce workstream). In addition, the IT workstream will be highly interdependent with general project implementation for Domain 2 & 3 project-specific strategies and their Domain 1 requirements. Elements of IT governance may be dependent on the Governance workstream since the Business Operations & Information Technology Subcommittee and other elements of IT governance will be integrated into overall OneCity Health governance. Finally, to the extent that meeting connectivity and EHR certification requirements requires financial investment, the PPS is dependent on capital funding requested through the Capital Restructuring Financing Program.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
IT Management and Support	HHC Enterprise IT Services (EITS)	Complete Integrated OneCity Health IT strategy. Manage QE relationships, and HHC/QE integration/interfaces. Manage overall IT implementation Strategy (central and partner connectivity).
Partner IT Liaisons	TBD – 1 per partner	Connectivity adoption, implementation, integration and support at own organization (for participation in OneCity Health). Data exchange support.
Support Infrastructure	OneCity Health Central Services Organization	Partner network relationship management and program management for implementation/ integration support. Project management and coordination.
PPS Governance Leadership	OneCity Health Executive Committee	Approval of certain IT governance decisions.
PPS Governance Entity	OneCity Health Care Models Subcommittee	Advice related to integrated DSRIP IT strategy.
PPS Governance Entity	OneCity Health Business Operations & Information Technology Subcommittee	Approval of certain IT governance decisions and oversight of certain IT processes and expenditures.
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Advice related to patient engagement in certain IT systems and processes.
PPS Governance Entity	OneCity Health Hub Steering Committees	Advice related to local implementation requirements of integrated DSRIP IT strategy.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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		
Attributed Patients and Families/Caregivers	Recipient of care services delivered with support of effective IT	Interaction sufficient to participate and take limited accountability for health and care-related activities.
OneCity Health CSO Business and IT Staff	Accountable for project management, integration and effective use of IT in PPS services	Oversight and integration of IT into OneCity Health operations Project management.
OneCity Health Governance Committee Members	Governance for effective integration and use of IT, centrally and across partners	Oversight and integration of IT into OneCity Health operations.
HHC Management/Leadership	Fiduciary oversight for effective integration and use of IT in OneCity Health operations	Oversight and integration of IT into OneCity Health and HHC operations.
HHC Enterprise IT Services (EITS) Leadership and Staff	Primary leadership and operational support	Coordinate, support and maintain coordinated OneCity Health (and HHC) IT solutions.
Partner Organization Providers and Staff	Project management, integration, connectivity and effective use of OneCity Health IT solutions	Adopt, implement, use and support integrated OneCity Health IT solutions, depending on role.
External Stakeholders		
QE Management/Leadership and Staff	Accountable for integration of key QE-supplied IT functionality for OneCity Health support	Oversight and integration of QEs into OneCity Health operations.
Community Advocates/Leaders/Elected Officials	Awareness of how IT is being used to effectively support OneCity Health and patients in the community at-large	Consume stakeholder communication and participation in stakeholder events.
Community Members/Public At-Large	Awareness of how IT is being used to effectively support OneCity Health and patients in the community	Consume stakeholder communication and participation in stakeholder events.
Non-Partner Providers	Awareness of how IT is being used to effectively support patients in the community and how they can participate in IT and connectivity-related solutions related to OneCity Health	QE participation as warranted to effectively treat patients.
Medicaid Managed Care Organizations (MCOs)	Awareness of how IT is/can be used to serve covered members	Contribute data and participate in QE and other IT solutions as warranted to effectively serve members.
DOHMH	Awareness of how IT is being used by OneCity Health	Offer solutions, participate in OneCity Health IT solutions in order to serve residents.
NYSDOH	Provide guidance and tools, including MAPP/SIM, to support OneCity Health use of IT	Guidance and tools to support OneCity Health IT use, including for efficient performance management and DOH reporting.
Labor Unions	Awareness of how IT is being used by OneCity Health	Member labor support for and training on OneCity Health IT solutions, as warranted.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Key stakeholders	Role in relation to this organizational workstream	Key deliverables / responsibilities
Other PPSs	Awareness of how IT is being used to effectively support patients in the community and how multiple PPSs may be able support each other's or share IT solutions	Participation in joint IT planning and solution development as warranted.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 5.7 - Progress Reporting

Instructions :

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

Successful design and deployment of an IT systems and processes approach will be measured by the Central Services organization along the following dimensions:

• Governance participation – Multi-stakeholder representation and participation in Business Operations & Information Technology Subcommittee meetings;

• Strategy/Solution Development – Timely completion of current state assessment, IT connectivity roadmap, data sharing plan, etc. according to the milestone dates outlined for this workstream;

• QE Adoption and Integration – Percentages of providers using OneCity Health-affiliated QEs and patients consenting to disclosure, tracked using the partner network management database; and

• Meaningful Use tracking – Percentages of required providers meeting MU standards, tracked using the partner network management database.

IPQR Module 5.8 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1: Identify and list all clinical pathways related to DSRIP.	In Progress	Step 1: Identify and list all clinical pathways related to DSRIP.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Determine individuals responsible for outcomes of clinical pathways and for financial outcomes.	In Progress	Step 2: Determine individuals responsible for outcomes of clinical pathways and for financial outcomes.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Establish requirements and metrics for clinical quality and performance dashboards.	In Progress	Step 3: Establish requirements and metrics for clinical quality and performance dashboards.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: Develop draft performance reporting and communications strategy, including: (1) identification of individuals responsible for clinical and financial outcomes of specific patient populations; (2) plans for the creation and use of clinical quality and performance dashboards; and (3) approach to rapid cycle evaluation.	In Progress	Step 4: Develop draft performance reporting and communications strategy, including: (1) identification of individuals responsible for clinical and financial outcomes of specific patient populations; (2) plans for the creation and use of clinical quality and performance dashboards; and (3) approach to rapid cycle evaluation.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: Define the content of and the production	In Progress	Step 5: Define the content of and the production model for clinical, administrative, and financial reports and analyses to	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
model for clinical, administrative, and financial reports and analyses to ensure PPS performance and to meet DSRIP requirements.		ensure PPS performance and to meet DSRIP requirements.							
Task Step 6: Review of draft performance reporting and communications strategy by partners.	In Progress	Step 6: Review of draft performance reporting and communications strategy by partners.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 7: Review and consensus-driven recommendation of draft performance reporting and communications strategy by Care Models and Business Operations & Information Technology Subcommittees.	In Progress	Step 7: Review and consensus-driven recommendation of draft performance reporting and communications strategy by Care Models and Business Operations & Information Technology Subcommittees.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 8: PPS Executive Committee approves performance reporting and communications strategy document.	In Progress	Step 8: PPS Executive Committee approves performance reporting and communications strategy document.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
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.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Identify training requirements to meet PPS clinical quality and performance reporting standards.	In Progress	Step 1: Identify training requirements to meet PPS clinical quality and performance reporting standards.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 2: Conduct baseline current state analysis of existing quality/performance reporting training programs across the PPS, including those conducted by MCOs.	In Progress	Step 2: Conduct baseline current state analysis of existing quality/performance reporting training programs across the PPS, including those conducted by MCOs.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Determine IT requirements for training program, such as learning management system.	In Progress	Step 3: Determine IT requirements for training program, such as learning management system.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 4: Leveraging existing best practices and in coordination with other education and training activities, develop plan to establish training program, including requirements for CBO contracts.	In Progress	Step 4: Leveraging existing best practices and in coordination with other education and training activities, develop plan to establish training program, including requirements for CBO contracts.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Establish process to monitor and report on participation in training programs.	In Progress	Step 5: Establish process to monitor and report on participation in training programs.	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6: Identify potential CBOs to carry out training program.	In Progress	Step 6: Identify potential CBOs to carry out training program.	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3	
Task Step 7: Finalize performance reporting training program and execute contracts as appropriate.	In Progress	Step 7: Finalize performance reporting training program and execute contracts as appropriate.	04/01/2016	03/31/2017	04/01/2016	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
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.	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Risk: The first risk we have identified is the variability in health IT capabilities and levels of experience in data-driven population health and quality improvement activities. Variation exists around collecting and using clinical and care management data, reporting, and population health management tools to shape care delivery.
Mitigation: We have two mitigation strategies to address this risk. First, we will seek to better understand partner reporting capabilities through our partner readiness assessment process. Second, we will work with partners to provide training on PPS care management tools, interpreting reports, and using these data to improve clinical outcomes.

Risk: We also anticipate a risk associated with effectively defining and communicating performance standards and expectations across the PPS. Because the PPS will evolve as a "learning organization," it will be challenging to set expectations in Demonstration Year 1 as the PPS will mature and standards will change.
Mitigation: To mitigate this risk, we will focus on a robust communications process with partners and adjusting our approach and standards as needed to ensure DSRIP performance and the delivery of high-quality, patient-centered care.

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.)

This workstream is dependent on workstreams related to workforce and practitioner engagement. Both workstreams include training and education activities, and our PPS seeks to harmonize all DSRIP-related training in order to reduce the burden on providers and staff and ensure a coordinated approach.

The care management and performance reporting workstreams are interdependent in important ways. The care management model that OneCity Health defines will directly affect the types of reports and content of those reports that care managers will use to manage day-to-day tasks and patient interactions. Because of this, care managers will be involved early in the process of defining the technical specifications of reports and will work closely with staff charged with application development.

This workstream is also dependent upon a number of IT components, as described under IT expectations for this workstream. First, identification and implementation of a learning management system, as described throughout this implementation plan, will facilitate education and training related to performance. Second, data sharing will be key to monitoring performance.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
PPS Clinical Leadership	PPS Chief Clinical Officer: Anna Flattau, MD	Spearhead performance measurement selection process; provide quality oversight and input into strategies to address low-performing providers.
PPS Governance Leadership	OneCity Health PPS Executive Committee: Ross Wilson, MD, Chair	Review and approve performance reporting and communications strategy. General DSRIP oversight.
PPS Governance Leadership	Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review and recommend draft performance reporting and communications strategy.
PPS Governance Leadership	Business Operations & Information Technology Subcommittee: Chair TBD; staffed by Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation, and OneCity Health Services Finance Director	Review and recommend draft performance reporting and communications strategy.
Support Infrastructure	PPS Central Services Organization, OneCity Health Services : Christina Jenkins, MD, CEO; Anna Flattau, MD, Chief Clinical Officer; Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manattan Hub Executive Director TBD; Hub Program Managers: Caroline Cross (Manhattan); Rachael Steimnitz (Brooklyn); Erfan Karim (Queens); Lindsay Donald (Bronx)	Support development of a training programs, participant-level data needs, and training outcomes.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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		
Providers	PPS Partners	Ensure PPS can collect performance data as needed
Community based organizations	PPS Partners	Ensure PPS can collect performance data as needed; support for implementing performance reporting training program as needed
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide Performance Reporting approaches
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide Performance Reporting approaches
Consumers	PPS patients and families	Coordination to ensure performance metrics are patient and family centric

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

First, identification and implementation of a learning management system, as described throughout this implementation plan, will facilitate education and training related to performance. Second, data sharing will be key to monitoring performance on both clinical and financial metrics and producing dashboards on both. The PPS is establishing a centralized performance management analytics and reporting environment to store normalized claim, clinical and other patient-level data in HHC's Business Intelligence/Enterprise Data Warehouse based on the IBM Provider Data Model. We expect that the dashboards produced using this system will help drive improved quality and performance reporting.

IPQR Module 6.8 - Progress Reporting

Instructions :

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

We will measure the success of this workstream across three broad dimensions. First, we must develop the two deliverables (performance reporting and communications strategy, performance training program) within the implementation plan timeframe. Second, we must submit PPS-wide metrics, as outlined in Attachment J and the Domain I metrics. Third, we must develop and implement a strategy for the rapid cycle evaluation of our PPS, thus enabling us to identify areas of strength and to target areas for improvement.

IPQR Module 6.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Develop draft practitioner communication and engagement plan which leverages the Hub-based PPS structure to identify local practitioner needs, builds on existing professional groups, and addresses: (1) plans for creating PPS-wide professional groups/communities and their role in the PPS structure; (2) development of standard performance reports to professional groups; and (3) identification of profession/peer-group representatives for relevant governing bodies.	In Progress	Step 1: Develop draft practitioner communication and engagement plan which leverages the Hub-based PPS structure to identify local practitioner needs, builds on existing professional groups, and addresses: (1) plans for creating PPS-wide professional groups/communities and their role in the PPS structure; (2) development of standard performance reports to professional groups; and (3) identification of profession/peer-group representatives for relevant governing bodies.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Solicit input from key partners and practitioners identified during the planning process as local planning champions; revise plan.	In Progress	Step 2: Solicit input from key partners and practitioners identified during the planning process as local planning champions; revise plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Plan reviewed and recommended by	In Progress	Step 3: Plan reviewed and recommended by Patient and Stakeholder Engagement Subcommittee.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Patient and Stakeholder Engagement Subcommittee.									
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.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Develop draft training/education plan targeting practitioners and other professional groups, designed to educate them about DSRIP and the OneCity Health quality improvement agenda.	In Progress	Step 1: Develop draft training/education plan targeting practitioners and other professional groups, designed to educate them about DSRIP and the OneCity Health quality improvement agenda.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 2: Solicit input from key partners and existing professional groups, and revise plan.	In Progress	Step 2: Solicit input from key partners and existing professional groups, and revise plan.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Review and consensus-driven recommendation of plan by Care Models Subcommittee and Stakeholder & Patient Engagement Subcommittee.	In Progress	Step 3: Review and consensus-driven recommendation of plan by Care Models Subcommittee and Stakeholder & Patient Engagement Subcommittee.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop Practitioners communication and engagement plan.	
Develop training / education plan targeting practioners and other professional groups, designed to educate them about the DSRIP program and your PPS-specific quality improvement agenda.	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Risk: The first major risk to the implementation is the broad geographic reach of OneCity Health providers and partners, as well as high variance in IT infrastructure and capability, which will make our engagement efforts challenging.
Mitigation: To mitigate this risk, we intend to identify clinical champions as needed and leverage our Hub-based governance structure.

Risk: The second risk we have identified is the amount of training that must be developed and deployed across OneCity Health. It will be challenging for providers and staff to adjust schedules and reduce patient/client loads in order to engage in training.
Mitigation: To mitigate this risk, we intend to develop a training/education plan that is sensitive to the busy schedules of our providers and staff. Although we don't anticipate being able to reduce the time burden associated with training, providing a rational, staged process for education that is responsive to busy schedules is one strategy to reduce the burden.

IPQR Module 7.4 - Major Dependencies on Organizational Workstreams

Instructions :

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

The training and education plan is related to activities around Workforce transformation in that all PPS training and education activities – including those targeted toward clinicians and staff – should be harmonized into a single cohesive approach.

This workstream is also highly dependent on the successful completion of planning related to clinical guidelines and process and operational workflows. This work must be largely complete before training on clinical standards and care pathways can be designed and deployed.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Support Infrastructure	OneCity Health Services: Christina Jenkins, MD, CEO; Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Accountable for development of draft practitioner engagement and training plans.
PPS Governance Entity	OneCity Health Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review draft practitioner engagement and training plans.
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Review draft practitioner engagement and training plans.
Workforce Training Vendor	TBD	Work with Central Services Organization to develop and deploy materials and training.
Clinical Champions	Initial Champions include 50+ cross-partner Clinical Leadership Team members convened to support clinical planning; Additional champions to be identified throughout DY1-DY2 implementation process	Local practitioners identified as champions during the clinical planning process.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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		
1199 SEIU	PPS Partners	Participation on PAC and input into education and training
CIR/SEIU	PPS Partners	Participation on PAC and input into education and training
DC37	PPS Partners	Participation on PAC and input into education and training
Doctors Council	PPS Partners	Participation on PAC and input into education and training
New York State Nurses Association (NYSNA)	PPS Partners	Participation on PAC and input into education and training
United University Professions (UUP)	PPS Partners	Participation on PAC and input into education and training
Civil Service Employees Association (CSEA)	PPS Partners	Participation on PAC and input into education and training
Public Employees Federation (PEF)	PPS Partners	Participation on PAC and input into education and training
Graduate Student Employee Union	PPS Partners	Participation on PAC and input into education and training
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide Practitioner Engagement Approaches
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide Practitioner Engagement Approaches

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

OneCity Health will implement and utilize a commercial customer relationship management (CRM) system (Salesforce.com), to manage our partner network, including physicians. The CRM will support physician communication and engagement, track phone, mail, email and other interactions, and manage engagement campaigns to reach groups of physicians.

OneCity Health will engage physicians in care management, population health management and other key aspects of DSRIP-related care coordination by building awareness of the capabilities of the planned centralized care coordination management solution (CCMS). Through demos, other events and other communications, OneCity Health will explain CCMS benefits and capabilities, focusing on how the system will help provide better service and outcomes to their patients and make their practices more efficient, allowing them to deliver higher quality patient care through functions such as:

- Providing multi-lingual, multi-cultural care navigation and support;
- Tracking and assisting patients with practice selection, active engagement in DSRIP programs, utilization tracking and pediatric-adult transition;
- Assisting patients with locating and accessing community resources, including for palliative care;
- Supporting transitions and warm handoffs at discharge, with follow-up tracking;
- Educating patients and families about wellness and care, and supporting patients in self-management and shared decision making related to their health needs; and
- Surveying patients and families regarding care experience.

In addition, physician training in evidence-based medicine, care coordination, population health management and other topics pertinent to DSRIP and OneCity Health standardization will be scheduled, delivered and tracked using a learning management system (LMS) administered by the OneCity Health Central Services Organization.

IPQR Module 7.8 - Progress Reporting

Instructions :

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

We will measure success of this workstream through the completion of two deliverables: the draft practitioner engagement plan and the completion of a draft education/training plan. Because of the size and scope of the OneCity Health PPS, reporting against progress associated with the deployment of these plans will likely require both Hub-level and PPS-level reporting and management processes.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 7.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1: Develop current-state assessment of PPS population health management capabilities and a definitive list of PCMH-eligible practices and certification status of each eligible practice through partner readiness assessment.	Completed	Step 1: Develop current-state assessment of PPS population health management capabilities and a definitive list of PCMH-eligible practices and certification status of each eligible practice through partner readiness assessment.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Based on Community Needs Assessment (CNA) data and building on application findings, identify priority target populations.	In Progress	Step 2: Based on Community Needs Assessment (CNA) data and building on application findings, identify priority target populations.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Develop OneCity Health population health management future state vision schema document, incorporating feedback from key internal and external stakeholders.	In Progress	Step 3: Develop OneCity Health population health management future state vision schema document, incorporating feedback from key internal and external stakeholders.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Identify IT infrastructure needed to support population health management vision.	In Progress	Step 4: Identify IT infrastructure needed to support population health management vision.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Identify overarching plans to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 certification by the end of DY3, and a plan to address health disparities of target populations; incorporate into overarching Population Health Management Roadmap.	In Progress	Step 5: Identify overarching plans to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 certification by the end of DY3, and a plan to address health disparities of target populations; incorporate into overarching Population Health Management Roadmap.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: Present Population Health Management Roadmap report to PPS Executive Committee for review and approval.	In Progress	Step 6: Present Population Health Management Roadmap report to PPS Executive Committee for review and approval.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Milestone #2 Finalize PPS-wide bed reduction plan.	In Progress	PPS Bed Reduction plan, signed off by PPS Board. This should set out your plan for bed reductions across your network, including behavioral health units/facilities, in line with planned reductions in avoidable admissions and the shift of activity from inpatient to outpatient settings.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Design approach to estimate future inpatient utilization, given shift in activity to outpatient settings and DSRIP goal of reduced preventable admissions and readmissions.	In Progress	Step 1: Design approach to estimate future inpatient utilization, given shift in activity to outpatient settings and DSRIP goal of reduced preventable admissions and readmissions.	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2: Estimate the potential impact of inpatient utilization changes on total PPS bed capacity needs, taking into account the drivers of inpatient supply specific to given geographies.	In Progress	Step 2: Estimate the potential impact of inpatient utilization changes on total PPS bed capacity needs, taking into account the drivers of inpatient supply specific to given geographies.	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 3: With appropriate stakeholder input, create report that outlines viable plan for addressing any identified excess inpatient PPS capacity.	In Progress	Step 3: With appropriate stakeholder input, create report that outlines viable plan for addressing any identified excess inpatient PPS capacity.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 4: Present plan to PPS Executive Committee for review and approval.	In Progress	Step 4: Present plan to PPS Executive Committee for review and approval.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.	
Finalize PPS-wide bed reduction plan.	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

Risk: Given the size and complexity of our network, it may be difficult to quickly gain a thorough understanding of the various population health capabilities of our partners.
Mitigation: We have begun implementing a comprehensive "Partner Readiness Assessment" in order to rapidly gain an effective understanding of our network and its various population health-related assets.

Risk: Given the size and complexity of our network, and the large number of PCMH-eligible practices,
bringing all practices up to the required standards by the end of DY3 presents a challenging task. There are some PCMH eligible partners (primary care providers) who do not currently have an EHR. Being able to meaningfully use an electronic health record is important part of meeting PCMH. Depending on the timing of an EHR procurement, implementation, and training, these providers may be unable to achieve PCMH Level 3 2014 Standards by the end of DY3. The same will hold true for those eligible providers who may be beginning Meaningful Use Stage 1 Year 1 in 2016. They will likely not be far enough along (in Stage 2) in order to meet the PCMH reporting requirements by the end of DY3.
Mitigation: We plan to implement a robust "Path to PCMH" program in order to assist our eligible partners in meeting the relevant PCMH requirements by DY3 as much as possible and will be in close communication with the State on progress and emerging risks to timing as DY3 approaches.

Risk: A robust population health management capability relies on the seamless flow of information, health information exchange (HIE), across different partners and sites of care. Effectively implementing these capabilities will be slow and tedious and will require difficult decisions to be made around which platforms will be used, how the platforms will "talk" to each other, standards for tracking care management interactions, etc. An important part of our HIE strategy relies on successfully integrating our clinical provider partners to the RHIOs/SHIN-NY by the end of DY3. If the RHIOs/SHIN-NY cannot adequately meet our needs in this timeframe, or at all, then we may need to alter our strategy well into the DSRIP timeline.
Mitigation: As part of our Partner Readiness Assessment, we plan to evaluate current partners IT capabilities and from that assessment, formulate a strategy related to the implementation of a care management platform, partner connectivity and information exchange, and the development of standards for care management activities. Unfortunately, relying on the RHIOs/SHIN-NY as a central strategy for HIE places a large part of this process out of the control of OneCity Health. In an effort to mitigate the potential risks associated with the RHIOs/SHIN-NY, we are exploring the option of building our own private HIE.

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.)

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Population health management strategy will be dependent on adequately assessing and training the proper workforce to deliver care in a population health model. Population health management strategy will be dependent on ensuring that care coordination and care management services are available in a culturally competent and language- and culture-specific manner.

Population health management strategy will be dependent on ensuring the PPS has adequate care coordination and management infrastructure and health information exchange to ensure near-real time and actionable information flow and information tracking across various providers within the PPS.

Population health management strategy will be dependent on ensuring the PPS has adequate reporting, measurement, and analytics capabilities to both meet state requirements and continuously improve PPS performance.

Population health management strategy will be dependent on robust practitioner engagement, especially around the redesign of various care models to a patient- and family-centered, population health-driven model of care.

Population health management strategy will be dependent on seamless information sharing across providers and ensuring consistent use of evidence-based medicine practices.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Strategic Planning and Operations Support	OneCity Health Services: Christina Jenkins, MD, CEO	Develop a population health management roadmap and bed reduction plan. Provide support for PCMH-eligible partners in achieving certification.
Care Coordination and Care Management Platform	Platform vendor: GSI; PPS IT Leadership team: Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation; Diana Amrom, OneCity Health Services IT Project Manager; Gerardo Escalera, HHC EITS DSRIP Project Management Lead	Care coordination and management vendor platform.
IT Strategy and Support	Sal Guido, Interim HHC Corporate CIO and Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation	Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "end state."
PPS Governance Leadership	OneCity Health Executive Committee: Ross Wilson, MD, Chair	Final approval of plans.
PPS Clinical Governance Leadership	OneCity Health Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Recommendation of plans.
HIE Qualified Entities	Bronx RHIO, Healthix, Interboro	Partner connectivity.
PCMH Support Vendor	Vendor TBD; PCMH technical assistance strategy lead: Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Provide support for PCMH-eligible partners in achieving certification.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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		
Health Homes and other Care Management Organizations	VNSNY, CHN, CBC, HHC, and others	Provide care coordination & management services
Hospital partners	HHC Facilities, SUNY	Participate in care coordination & management services
Community Based Organizations	Various	Participation in patient outreach and engagement activities
External Stakeholders		
Managed Care Organizations	MetroPlus, HealthFirst and others	Provide care coordination & management services; collaborate to expand value-based payment contracting arrangements

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

Current population health management IT capabilities in the PPS are largely at the partner or facility level. Health Homes and their care management agencies, along with other care management-focused OneCity Health partners, are using small scale care management solutions. Other partners are using homegrown analytics to track patients across settings and within condition cohorts that could be considered to be ad hoc patient registries.

A primary objective of our PPS is to develop a standard approach to population health management across all PPS partners based on a new IT infrastructure. Features will leverage tools already in place or being implemented at HHC that may not be currently utilized for population health management. Our plan for leveraging and developing a new and integrated IT infrastructure for population health management includes the following:

• Establish a centralized performance management analytics and reporting environment to store patient-level data in HHC's Business Intelligence/Enterprise Data Warehouse. HHC will optimize its performance management business intelligence analytics platform for DSRIP and population health stakeholder readiness. New capabilities will use the existing platform to create an automated registry functionality, clinical and claims based data aggregation, NYS required MDF reporting functionality for OneCity Health, and eventually dashboards with detailed information and performance analytics to support clinical programs.

• Implement a Clinical Record Locator Service (CLRS). Creating a master data management (MDM) environment and a CLRS for patient and provider matching and PPS-wide identification is a high priority. OneCity Health partners must be able to provide accurate, safe, secure, and timely exchange of patient information to providers across a multitude of facilities and systems. The foundational element of this integrated system is the ability to accurately identify and link patient records across the PPS. The CRLS will be critical for care coordination, transitions of care, and operational monitoring and reporting.

• Use the DOHMH Medicaid Analytics Provider Portal (MAPP) for additional analysis and reporting.

• Implement a common commercial care coordination and management solution (CCMS) for use across HHC and other PPS partners, which will serve as a central location for all PPS providers to enable successful population health management. We expect the platform will provide our PPS with the ability to (at a minimum): (1) risk stratify members, (2) track outreach and patient engagement, (3) create care teams and mechanisms for communication within the team, (4) document appropriate patient centered assessments, (5) create care plans, (6) track outcomes for continual improvement, and (7) receive real time event notification alerts (ADTs).

• Contract with and build interfaces to the three regional health information exchanges/Qualified Entities in OneCity Health's coverage area – Bronx RHIO, Healthix, Interboro –to achieve required data sharing among PPS partners and between electronic medical records and the CCMS, and potentially with other PPSs. This will require assessing the current state of PPS partner's IT capabilities and assessing the level of complexity

New York City Health and Hospitals Corporation (PPS ID:52)

and effort to connect. The PPS will develop and implement a phased plan for connecting partners to one of the NYC QEs beginning with high volume partners who are not already connected.

• Help partners implement certified EHRs, adopt and integrate with RHIO services and, if eligible, use the combined IT infrastructure to achieve PCMH 2014 recognition, all to perform population health management effectively and efficiently.

• Implement robust and secure IT network and communications infrastructure to support these solutions and a patient contact center that supports population health management.

IPQR Module 8.8 - Progress Reporting

Instructions :

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

Success of this workstream will be measured by the following milestones, to be tracked with support from the Central Services Organization (CSO):

• Number of partners who actively use care coordination and management platform or other relevant tools;

• Number of eligible practices that have achieved NCQA PCMH recognition;

• Approval of population health management roadmap by Executive Committee; and

• Approval of bed reduction plan by Executive Committee.

IPQR Module 8.9 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Building on data collected as part of Partner Readiness Assessment process, collect any additional data from partners required to determine needs and capabilities with regard to: data sharing and interfaces, IT system interoperability, care coordination/ management, care transitions including ED and inpatient discharge, and care team communication.	Completed	Step 1: Building on data collected as part of Partner Readiness Assessment process, collect any additional data from partners required to determine needs and capabilities with regard to: data sharing and interfaces, IT system interoperability, care coordination/ management, care transitions including ED and inpatient discharge, and care team communication.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Based on data collected and identified best practices across the PPS network, create a clinical integration needs assessment, including mapping providers in the network, requirements, key data points for shared access, key interfaces, and other potential mechanisms to drive clinical integration.	In Progress	Step 2: Based on data collected and identified best practices across the PPS network, create a clinical integration needs assessment, including mapping providers in the network, requirements, key data points for shared access, key interfaces, and other potential mechanisms to drive clinical integration.	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 3: Care Models Subcommittee reviews and makes consensus-driven recommendation on needs assessment.	In Progress	Step 3: Care Models Subcommittee reviews and makes consensus-driven recommendation on needs assessment.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: OneCity Health Executive Committee reviews and approves needs assessment.	In Progress	Step 4: OneCity Health Executive Committee reviews and approves needs assessment.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #2 Develop a Clinical Integration strategy.	In Progress	Clinical Integration Strategy, signed off by Clinical Quality Committee, including: -- Clinical and other info for sharing -- Data sharing systems and interoperability -- A specific Care Transitions Strategy, including: hospital admission and discharge coordination; and care transitions and coordination and communication among primary care, mental health and substance use providers -- Training for providers across settings (inc. ED, inpatient, outpatient) regarding clinical integration, tools and communication for coordination -- Training for operations staff on care coordination and communication tools	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Through the Business Operations and IT Committee, with support from the Central Services Organization, identify the key data elements required for sharing and the key relevant systems	In Progress	Step 1: Through the Business Operations and IT Committee, with support from the Central Services Organization, identify the key data elements required for sharing and the key relevant systems	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2: Convene Clinical Leadership Team to define PPS-wide guidelines for Care Transitions through care management plans and revise on an ongoing basis through the Care Models Committee	In Progress	Step 2: Convene Clinical Leadership Team to define PPS-wide guidelines for Care Transitions through care management plans and revise on an ongoing basis through the Care Models Committee	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	
Task Step 3: Synthesize PPS-wide Care Transitions guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	In Progress	Step 3: Synthesize PPS-wide Care Transitions guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Refine Care Transitions guidelines through hub-based planning process	In Progress	Step 4: Refine Care Transitions guidelines through hub-based planning process	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 5: Identify key training needs related to care coordination and communication tools as part of care management program planning process and in collaboration with the Stakeholder engagement Committee	In Progress	Step 5: Identify key training needs related to care coordination and communication tools as part of care management program planning process and in collaboration with the Stakeholder engagement Committee	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6: Leveraging these guidelines for care transitions and data sharing elements identified by Business Operations and IT Committee, develop strategy for clinical integration that includes: clinical and other info for sharing; data sharing systems and interoperability; a specific care transitions strategy; and training for providers and operations staff.	In Progress	Step 6: Leveraging these guidelines for care transitions and data sharing elements identified by Business Operations and IT Committee, develop strategy for clinical integration that includes: clinical and other info for sharing; data sharing systems and interoperability; a specific care transitions strategy; and training for providers and operations staff.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 7: Solicit feedback from relevant stakeholders and revise strategy.	In Progress	Step 7: Solicit feedback from relevant stakeholders and revise strategy.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 8: Review and consensus-driven recommendation by Care Models Subcommittee.	In Progress	Step 8: Review and consensus-driven recommendation by Care Models Subcommittee.	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 9: Approval by OneCity Health Executive Committee.	In Progress	Step 9: Approval by OneCity Health Executive Committee.	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4	

IA Instructions / Quarterly Update

Milestone Name	IA Instructions	Quarterly Update Description

No Records Found

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

Risk: The greatest risk will be to attempt to address the full scope of the PPS's clinical integration needs without the benefit of a targeted approach with regard to clinical integration.
Mitigation: We intend to mitigate this risk by basing integration goals on prior experience with regard to high-impact integration levers, specific project and organizational requirements identified in other workstreams, and on DSRIP Domain I process measures, clinical measures, and the Special Terms and Conditions. This will enable our PPS to effectively measure progress against goals and timeframes.

Risk: Partners may be challenged, financially or otherwise, to comply with clinical integration approaches, especially those who had not previously participated in data exchange or whose IT infrastructures may not meet certified MU requirements.
Mitigation: We will educate all partners on the importance of clinical integration and incorporate clinical integration requirements into their contracts. In addition, we will take a targeted, phased approach to Clinical Integration that takes into account differing levels of partner readiness.

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.)

The strategies developed in the Clinical Integration workstream are closely related to requirements and strategies that will be identified in the Workforce Strategy, IT Systems and Processes, Performance Reporting, Physician Engagement and Population Health Management workstreams. In addition, the Clinical Integration workstream will be highly interdependent with General Project Implementation, particularly for Domain 2 and 3 project-specific strategies and their Domain 1 requirements. Many of the goals and requirements of project 2.a.i are closely related to clinical integration. Finally, practitioner engagement will be a core component and prerequisite for establishing a clinically integrated network.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
PPS Clinical Leadership	Anna Flattau, MD, One City Health Services Chief Clinical Officer	Oversight of clinical integration needs assessment and strategy development
Support Infrastructure	OneCity Health Services : Christina Jenkins, MD, CEO; Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manattan Hub Executive Director TBD; Hub Program Managers: Caroline Cross (Manhattan); Rachael Steimnitz (Brooklyn); Erfan Karim (Queens); Lindsay Donald (Bronx)	Network management and program management for implementation/integration support; Project management and coordination.
PPS Governance Leadership	OneCity Health Executive Committee: Ross Wilson, MD, Chair	Review and approve relevant clinical integration strategies and decisions.
PPS Governance Entity	OneCity Health Care Models Subcommittee: Joseph Masci, MD, Chair; staffed by Anna Flattau, MD, OneCity Health Services Chief Clinical Officer	Review clinical integration decisions and provide oversight of certain clinical integration efforts.
PPS Governance Entity	OneCity Health Business Operations & Information Technology Subcommittee: Chair TBD; staffed by Juan Maluf, OneCity Health Services Senior Director for IT Strategies and Implementation, and OneCity Health Services Finance Director	Provide input related to clinical integration in certain IT systems and processes.
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Provide advice related to integrated DSRIP clinical integration strategy.
PPS Governance Entity	OneCity Health Hub Steering Committees; staffed by Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manattan Hub Executive Director TBD	Provide input related to local implementation requirements of clinical integration strategy.
Support Infrastructure	HHC Enterprise IT Services (EITS): Gerardo Escalera, HHC EITS DSRIP Project Management Lead	Integrated OneCity Health IT strategy; QE relationships; Integration/interfaces; Overall IT implementation strategy (central and partner connectivity)
Support Infrastructure	PPS Finance Director (Permanent Director TBD)	Review clinical integration expenditures.
Providers	PPS Partners	Input into clinical integration elements and process via hub-based planning process and the Project Advisory Committee
Community Based Organizations (CBOs)	PPS Partners	Input into clinical integration elements and process via hub-based planning process and the Project Advisory Committee

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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		
Attributed Patients and Families/Caregivers	Recipient of care services delivered with support of effective IT	Interaction sufficient to participate and take limited accountability for health and care-related activities
OneCity Health CSO Business and IT Staff	Accountable for project management of clinical integration initiatives PPS-wide	Oversight and integration of clinical integration into OneCity Health operations; Project management
HHC Management/Leadership	Fiduciary oversight for effective and compliant clinical integration	Oversight of clinical integration into OneCity Health operations
HHC Enterprise IT Services (EITS) Leadership and Staff	Leadership and operational support for IT-related clinical integration supports and data sharing	Coordinate, support and maintain coordinated OneCity Health (and HHC) IT solutions
Partner Organization Providers and Staff	Project management and effective adoption of OneCity Health clinical integration protocols and solutions	Adopt, implement, use and support clinical integration protocols and solutions, depending on role
Labor Unions	Awareness of how clinical integration is being used by OneCity Health	Member labor support for and training on OneCity Health clinical integration protocols, solutions and workforce supports, as warranted
External Stakeholders		
QE Management/ Leadership and Staff	Accountable for integration of key QE-supplied IT functionality for OneCity Health support	Oversight and integration of QE services into OneCity Health operations
Medicaid Managed Care Organizations (MCOs)	Awareness of how clinical integration is/can be used to serve covered members	Contribute data and participate in QE and other clinical integration solutions as warranted to effectively serve members
DOHMH	Awareness of and support for OneCity Health clinical integration	Offer solutions and guidance for compliant clinical integration in order to serve residents
NYSDOH	Provide guidance and tools for compliant clinical integration	Guidance and tools to support OneCity Health in implementing compliant clinical integration solutions
Other PPSs	Awareness of how clinical integration is being used to effectively support patients in the community and how multiple PPSs may be able support each other's clinical integration efforts	Participation in joint clinical integration planning and solution development as warranted

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

Nearly all components of OneCity Health's shared IT infrastructure will provide support for and will be critical to clinical integration. A centralized performance management and analytics environment will provide common data and outcomes measurement to bind together partners and help them track common integration results in a standardized way. A clinical record locator system and HHC-administered master data management system will provide a single integrated view of each patient and a unified, standard and navigable view of participating partners. A common care coordination management solution will add to the integrated view of the patient and provide a common tool for the care teams to interact and manage patients.

IPQR Module 9.8 - Progress Reporting

Instructions :

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

Clinical Integration success will be measured according to:

• Progress against integration-related Domain 1 milestones; and

• Tracking interaction among partners in the PPS.

IPQR Module 9.9 - IA Monitoring:

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

OneCity Health's approach to project implementation is to transform the PPS in a coordinated, measured and integrated fashion. We intend to support an implementation process that: leverages existing infrastructure; promotes partner/provider engagement and identifies areas to reduce burden; establishes clear expectations for performance; and results in high-quality patient-centered care. Key components of this approach include:

• As OneCity Health covers a large geographic area, with a broad range of partners and a diverse attributed population, we established a governance structure that would support the development of central standards that also reflect local planning. Our PPS organized its service area into four borough-based "hubs" to support a coordinated, locally-driven approach to planning. Each hub is led by a Steering Committee responsible for providing local leadership of DSRIP-related activities and reporting back to PPS-wide committees on local issues and best practices. In addition, each hub has a project advisory committee (PAC) to ensure the engagement of partners and stakeholders.

• Our clinical governance structure is designed to establish and support a process to develop clinical guidelines that provide sufficient standardization across the PPS while allowing for local flexibility. The development of clinical guidelines is aimed at identifying "must-have" elements to support our PPS in meeting DSRIP requirements and transformation goals. These PPS-wide guidelines are augmented to accommodate local variations in resources and capabilities and local operational workflows. This planning will occur primarily in DY 1; however, we anticipate revising and updating guidelines as needed. Guidelines and processes will be reviewed and recommended by the Care Models Subcommittee. This work will be supported by robust analytics and performance monitoring activities.

• To be successful in DSRIP, education, training, engagement and communication among providers and staff will be crucial. Given the breadth and depth of these needs, we must establish a coordinated plan to identify training and education needs across the PPS, establish requirements for the development and delivery of the training, and determine areas for partner participation. Training around cultural competency must be incorporated to ensure that we are responsive to the diverse needs of our attributed population.

• A robust, IT-enabled population heath approach will rely on a range of capabilities, including the capability to share data across providers and access patient-level information organized in a secure, provider-friendly electronic format. As part of this work, we conducted a preliminary partner readiness assessment to understand partner capabilities across a broad range of PPS needs. Initial data from the partner readiness assessment will inform a longer-term plan to address gaps in our network and the deployment of a comprehensive population health management strategy.

• We are establishing a workforce strategy that will address recruitment, retention and redeployment needs. The strategy will be designed around goals of meeting the primary and preventive care needs of our attributed population and addressing existing gaps in care as a result of provider shortages. We anticipate the need for expanded care management and care coordination capacity as well. A central tenet of our strategy will be to

New York City Health and Hospitals Corporation (PPS ID:52)

ensure that our workforce includes culturally and linguistically responsive providers and staff.

• We are developing an approach to financial sustainability that will enable the PPS to expand its existing and extensive value-based contracting, support the PPS infrastructure needs, leverage high standards for accountability and transparency and leverage existing infrastructure and best practices.

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.

Our overall implementation approach will rely on an adequate and effective workforce that has the training and education they need. Population health management strategy will be dependent on adequately assessing and training the proper workforce to deliver care in a population health model.

Outreach, engagement and care delivery must be provided in a way that meets the diverse language and cultural needs of our population.

Ensuring the PPS has the IT tools it needs to support care delivery, performance reporting, patient management and tracking, and care delivery is critical to almost every goal within the PPS. In addition, as part of a data-driven approach to performance improvement, our PPS must have adequate reporting, measurement, and analytics capabilities.

Finally, robust practitioner engagement, especially around the redesign of various care models, is critical to providing high-quality, patient centered care in a population health driven model.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Support Infrastructure	OneCity Health Central Services Organization	Project management and coordination; Data analytics and performance monitoring
PPS Governance Leadership	OneCity Health Executive Committee	Oversight of DSRIP implementation and performance
PPS Governance Entity	OneCity Health Care Models Subcommittee	Guidance related to clinical quality and care model design
PPS Governance Entity	OneCity Health Business Operations & Information Technology Subcommittee	Guidance related to business functions and information technology
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Guidance related to outreach, education and communications strategies for stakeholders and patients
PPS Governance Entity	OneCity Health Hub Steering Committees	Input related to local implementation requirements of clinical integration strategy
Support Infrastructure	HHC Enterprise IT Services (EITS)	Overall IT implementation strategy (central and partner connectivity); Integrated OneCity Health IT strategy; QE relationships; Integration/interfaces

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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		
Attributed Patients and Families/Caregivers	Recipient of care services delivered with support of effective IT	Interaction sufficient to participate and take limited accountability for health and care-related activities
HHC Management/Leadership	Fiduciary oversight for effective and compliant clinical integration	Oversight of clinical integration into OneCity Health operations
OneCity Health Partners	Project management and effective project implementation	Guidance on and responsibility for project implementation, provider and staff engagement, and performance
Medicaid Managed Care Organizations (MCOs)	Support for identification, outreach and management of patients	Contribute data and participate in QE and other clinical integration solutions as warranted to effectively serve members
HHC Enterprise IT Services (EITS) Leadership and Staff	Leadership and operational support for IT-related clinical integration supports and data sharing	Coordinate, support and maintain coordinated OneCity Health (and HHC) IT solutions
External Stakeholders		
QE Management/ Leadership and Staff	Accountable for integration of key QE-supplied IT functionality for OneCity Health support	Oversight and integration of QE services into OneCity Health operations
RHIOs/SHIN-NY	Accountable for making HIE functionality available and onboarding partners	Functionality required as a result of DSRIP
DOHMH	Collaboration to support shared goals	Provide expertise and a forum for collaboration as needed
Labor Unions	Support for education and training	Support for and training on OneCity Health operational workflows

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

To support implementation and ongoing management of DSRIP projects and to act as an effective integrated delivery system, OneCity Health will require and implement a robust IT infrastructure.

- Care Coordination & Management: HHC is in the process of contracting for a care coordination management solution (CCMS) for population stratification, patient engagement, patient assessment, care planning, clinical and social service navigation, care transition management, patient registries and care management workflow, capacity and task management. HHC will implement this platform for its Health Home and OneCity Health expects to use the platform for DSRIP internally and among its PPS partners.

- Clinical Record Locator Service (CRLS): Each patient within the PPS will need a unique patient ID number that is available to providers at all points of care. OneCity Health will create a clinical record locator service for patient and provider matching and PPS-wide identification and an overarching master data management (MDM) environment. We intend to also use IBM Infosphere and Initiate tools (also known as the MDM Suite).

- Health Information Exchange: Layered on top of the unique patient ID will be a robust healthcare information exchange (HIE) that operates across PPS entities and providers that will enable the exchange of information so patient data is accurate, and patients receive the right care without unnecessary duplication of services. OneCity Health's strategy to increase the availability and utilization of health information exchanges (HIEs) will be accomplished via connectivity to various Qualified Entities (QEs) across New York City. OneCity Health will develop and implement a phased plan for connecting PPS partners to one of the NYC QEs (Bronx, Healthix, Interboro) beginning with high volume partners that are not already connected.

- Performance Management and Analytics: In order to know whether clinical programs are working and to help reduce unnecessary admissions and ED visits on an individual and population level, OneCity Health will normalize and store claims, clinical and other patient-level data in HHC's Business Intelligence/Enterprise Data Warehouse based on the IBM Provider Data Model, creating a centralized performance management, analytics and reporting capability for the PPS. OneCity Health will also use the DOHMH Medicaid Analytics Provider Portal (MAPP) for additional population health management analysis and reporting.

- Unified Communications: OneCity Health will create a foundation for data sharing among hundreds of thousands of patients and care providers in a single controlled environment through upgrades to existing technology. To provide a consistent, unified user and patient communication system, infrastructure upgrades will be made to instant messaging, presence information, telephony, video conferencing, patient portal access, desktop sharing, data sharing and call control/management systems, and unified messaging integration (integrated voicemail, e-mail, SMS and fax).

- Telehealth and telemedicine: OneCity Health will have the ability to centralize the availability and management of patient care using IT and

New York City Health and Hospitals Corporation (PPS ID:52)

communications-supported telehealth methods.

□ - Assessment, Monitoring and Support Programs and resources: Based on a current state assessment of PPS partner capabilities against OneCity Health and DOH requirements, the OneCity Health Central Services Organization will establish program management services for monitoring or assisting PPS partners as required with acquiring EHRs certified for Meaningful Use attestation, achieving NCQA 2014 PCMH recognition and participating and integrating with QEs for health information exchange.

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.

As the lead applicant, HHC has engaged in many quality improvement projects across facilities within the system. Similarly, many other partners within the PPS have implemented their own initiatives related to improving outcomes and performance. DSRIP will serve as a unifying force for these varied and disparate activities. OneCity Health's Central Services Organization (CSO) will serve as the infrastructure to support quality performance reporting, through the development and implementation of performance reporting formats and tools. Performance reports will integrate Domain 1 process metrics, Domain 2 and 3 quality and outcome metrics, and other internal PPS clinical and performance metrics relevant to the successful implementation of DSRIP projects and continued progress toward meeting DSRIP goals.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

In formulating our PPS, we were guided by several core principles. First, our PPS should be organized around the needs of the patient, the family, and the community, with an emphasis on high-quality, patient-centered care that also addresses the social determinants of health. Thus, we engaged a large number of community-based organizations (CBOs) and partners to join our PPS. Second, our PPS's ability to deliver patient-centered care depends on a well-trained workforce focused on providing seamless care across the continuum. Third, our PPS will operate transparently with a strong bias towards inclusivity. Thus, our governance structure ensures that community-based partners hold a majority of the seats on our Executive Committee, and also provides ample opportunity for local involvement and guidance. Activities that we have undertaken in this regard include:

- Taking an inclusive approach to designing its Project Advisory Committee (PAC). It is structured to both represent and include all partners within the PPS. As described previously, our governance structure also includes hub-based PACs to ensure that input into planning at both the central and local levels represents partner views and expertise. Guiding principles include committing to: a shared vision of healthier communities, meaningful collaboration, and supporting the transformation journey.
- Designing and implementing a partner readiness assessment tool. This assessment addresses a broad range of information about partner resources, capacity and readiness to implement DSRIP projects. As a result of these data, our PPS will have a much more nuanced understanding of our existing assets and resources and where we may need to develop or deploy additional supports and services.

OneCity Health anticipates contracting with CBOs to support DSRIP implementation, including to broaden the availability of social services and supports, provide education and training to patients, families, providers and staff, and to support patient identification, activation and enrollment as part of the 11th Project. Once the partner readiness assessment process is complete, we will have a better understanding of our existing assets and resources as well as gaps that must be filled. Based on this data, and through the establishment of requirements for successful implementation of each project, we will utilize the contracting process outlined in the Governance section.
One risk we have identified is that the process to identify needs, establish contracting requirements, effectuate contracts, and then provide training and education, may have a longer time horizon than is optimal for DSRIP needs. To mitigate this risk we have prioritized our work to understand current partner capabilities and gaps that may need to be filled.

IPQR Module 10.8 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	Completed	Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to conduct current state survey of workforce impacted by DSRIP program.	In Progress	Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to conduct current state survey of workforce impacted by DSRIP program.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify drivers of change to consider in target workforce analysis.	In Progress	Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify drivers of change to consider in target workforce analysis.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify relevant populations and build target workforce state staffing scenarios.	In Progress	Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify relevant populations and build target workforce state staffing scenarios.	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4	
Task Step 5: Convene internal and external stakeholders for discussion and input on target state scenarios.	Not Started	Step 5: Convene internal and external stakeholders for discussion and input on target state scenarios.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: Present target-state workforce scenarios to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations &	Not Started	Step 6: Present target-state workforce scenarios to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Information Technology Subcommittee for review and recommendation.									
Task Step 7: Present target-state workforce scenarios to PPS Executive Committee for review and approval.	Not Started	Step 7: Present target-state workforce scenarios to PPS Executive Committee for review and approval.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
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.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2	NO
Task Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	Completed	Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment.	Not Started	Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify key milestones that PPS will need to achieve workforce transition.	Not Started	Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify key milestones that PPS will need to achieve workforce transition.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to prioritize workforce transition steps.	Not Started	Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to prioritize workforce transition steps.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify short and long term strategies to address workforce gaps; identify ability to address workforce gaps through training of existing staff or through long term strategies in partnerships with academic institutions.	Not Started	Step 5: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify short and long term strategies to address workforce gaps; identify ability to address workforce gaps through training of existing staff or through long term strategies in partnerships with academic institutions.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: Collaborate with cross-PPS vendor and	Not Started	Step 6: Collaborate with cross-PPS vendor and PPS Workforce Consortium to develop steps and corresponding	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	

New York City Health and Hospitals Corporation (PPS ID:52)

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 Workforce Consortium to develop steps and corresponding timelines in order for the PPS to meet the established milestones in alignment with the DSRIP program expectations; finalize draft workforce transition roadmap.		timelines in order for the PPS to meet the established milestones in alignment with the DSRIP program expectations; finalize draft workforce transition roadmap.							
Task Step 7: Convene internal and external stakeholders for discussion and input.	Not Started	Step 7: Convene internal and external stakeholders for discussion and input.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 8: Present workforce transition roadmap document to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	Not Started	Step 8: Present workforce transition roadmap document to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 9: Present workforce transition roadmap document to PPS Executive Committee for review and approval.	Not Started	Step 9: Present workforce transition roadmap document to PPS Executive Committee for review and approval.	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2	
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.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	NO
Task Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	Completed	Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment; identify key findings, patterns, and themes.	Not Started	Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment; identify key findings, patterns, and themes.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to perform gap analysis to compare and contrast current workforce state to future workforce state.	Not Started	Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to perform gap analysis to compare and contrast current workforce state to future workforce state.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Convene internal and external stakeholders for discussion and input.	Not Started	Step 4: Convene internal and external stakeholders for discussion and input.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 5: Present current state assessment report and gap analysis to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	Not Started	Step 5: Present current state assessment report and gap analysis to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: Present current state assessment report and gap analysis to PPS Executive Committee for review and approval.	Not Started	Step 6: Present current state assessment report and gap analysis to PPS Executive Committee for review and approval.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
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.	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1	YES
Task Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	Completed	Step 1: Coordinate with other NYC PPSs ("PPS Workforce Consortium") to select a vendor to conduct a cross-PPS workforce analysis to inform the target workforce state.	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3	
Task Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment.	Not Started	Step 2: Collaborate with cross-PPS vendor and PPS Workforce Consortium to collect and aggregate data from current state survey and target state assessment.	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4	
Task Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify positions that will likely require retraining and future state positions of retrained employees.	Not Started	Step 3: Collaborate with cross-PPS vendor and PPS Workforce Consortium to identify positions that will likely require retraining and future state positions of retrained employees.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to leverage data from current state assessment/gap analysis to	Not Started	Step 4: Collaborate with cross-PPS vendor and PPS Workforce Consortium to leverage data from current state assessment/gap analysis to identify workforce impacts that will inform the compensation and benefit analysis.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
identify workforce impacts that will inform the compensation and benefit analysis.									
Task Step 5: Collaborate with cross-PPS vendor and PPS Workforce Consortium to assess impact of compensation and benefits for new hires, retrained, and redeployed staff, using publicly available and internal benchmarking databases for wages and benefits.	Not Started	Step 5: Collaborate with cross-PPS vendor and PPS Workforce Consortium to assess impact of compensation and benefits for new hires, retrained, and redeployed staff, using publicly available and internal benchmarking databases for wages and benefits.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 6: Collaborate with cross-PPS vendor and PPS Workforce Consortium to develop draft compensation and benefits analysis; convene internal and external stakeholders for discussion and input.	Not Started	Step 6: Collaborate with cross-PPS vendor and PPS Workforce Consortium to develop draft compensation and benefits analysis; convene internal and external stakeholders for discussion and input.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 7: Present compensation and benefits analysis to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	Not Started	Step 7: Present compensation and benefits analysis to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Task Step 8: Present compensation and benefits analysis to PPS Executive Committee for review and approval.	Not Started	Step 8: Present compensation and benefits analysis to PPS Executive Committee for review and approval.	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1	
Milestone #5 Develop training strategy.	Not Started	Finalized training strategy, signed off by PPS workforce governance body.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	NO
Task Step 1: Based on current state assessment report and gap analysis, identify training and pipeline development needs across the PPS, by Hub.	Not Started	Step 1: Based on current state assessment report and gap analysis, identify training and pipeline development needs across the PPS, by Hub.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task Step 2: Based on anticipated roll-out and ramp-up schedule of projects by Hub, map timing of anticipated training needs within each Hub by role and by project, specific to care setting.	Not Started	Step 2: Based on anticipated roll-out and ramp-up schedule of projects by Hub, map timing of anticipated training needs within each Hub by role and by project, specific to care setting.	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	
Task	Not Started	Step 3: Conduct gap analysis of key skills required to	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter	AV
Step 3: Conduct gap analysis of key skills required to implement new delivery models by Hub.		implement new delivery models by Hub.							
Task Step 4: Identify partners within each Hub who have existing training capacity and resources to leverage.	Not Started	Step 4: Identify partners within each Hub who have existing training capacity and resources to leverage.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 5: For remaining training needs, contract with appropriate training vendors to meet identified needs.	Not Started	Step 5: For remaining training needs, contract with appropriate training vendors to meet identified needs.	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3	
Task Step 6: Develop draft training and pipeline development strategy document and convene internal and external stakeholders for discussion and input, including SUNY Downstate and other partners; document may include guiding principles, timing projections, and tactics to pursue—by Hub, by care setting, and by job classification.	Not Started	Step 6: Develop draft training and pipeline development strategy document and convene internal and external stakeholders for discussion and input, including SUNY Downstate and other partners; document may include guiding principles, timing projections, and tactics to pursue—by Hub, by care setting, and by job classification.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 7: Present training and pipeline development strategy document to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	Not Started	Step 7: Present training and pipeline development strategy document to PPS Stakeholder & Patient Engagement Subcommittee and Business Operations & Information Technology Subcommittee for review and recommendation.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4	
Task Step 8: Present training and pipeline development strategy document to PPS Executive Committee for review and approval.	Not Started	Step 8: Present training and pipeline development strategy document to PPS Executive Committee for review and approval.	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

NYS Confidentiality – High

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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).	
Create a workforce transition roadmap for achieving defined target workforce state.	
Perform detailed gap analysis between current state assessment of workforce and projected future state.	
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.	OneCity Health will address workforce compensation and benefits analysis as part of a broader engagement with a consortium of New York City-based PPSs and BDO Consulting, LLC – a vendor supporting workforce-related analyses and deliverables for the consortium. Now that the procurement process has concluded, work on the compensation and benefits analysis has commenced. As mentioned in workforce risks and mitigation strategies, the healthcare landscape in New York City is constantly evolving and there is a need to coordinate workforce-related analyses and deliverables across hundreds of partners and with other PPSs with overlapping service areas. With this in mind, OneCity Health is collaborating with Bronx Partners for Healthy Communities PPS, Brooklyn Bridges PPS, and Community Care of Brooklyn PPS (collectively "PPS Workforce Consortium") to develop and execute a cross-PPS workforce analysis. In late September 2015, the PPS Workforce Consortium collaborated to release an RFP to potential vendors to support workforce-related deliverables, and selected BDO Consulting, LLC as the vendor in mid-November 2015. BDO Consulting, LLC will engage two subcontractors (IHS and Center for Health Workforce Studies) to support their work with the PPS Workforce Consortium. OneCity Health has completed the procurement process mandated by our lead partner and fiduciary (NYC Health + Hospitals). Since concluding procurement, work with BDO has commenced. As part of their scope-of-work, BDO Consulting, LLC will support various workforce-related analyses and deliverables, including but not limited to the following: • Definition of target workforce state • Baseline workforce assessment • Gap analysis of baseline to target workforce state • Workforce impact analysis • Workforce transition roadmap • Compensation and benefits analysis The PPS Workforce Consortium is working with BDO Consulting, LLC individually and collectively to address survey design; messaging, dissemination and follow up strategy for PPS partners; identification and approach to engagement with overlapping PPS partners; survey data sharing parameters amongst PPSs; and analysis and presentation of various data cuts (individual PPS, borough, city-wide). The survey has been designed and finalized, and a schedule of activities for

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
	the first phase of collection of data has been agreed upon by the PPS Workforce Consortium and it includes: • Communication to all Partners explaining upcoming survey – week of January 25, 2016 • Survey distributed to Partners – week of February 1, 2016 • Webinars detailing process and steps - week of February 1, 2016 • Process and timeline for submission defined In addition, OneCity Health has held a number of meetings with labor partners to ensure their engagement in and obtain their input into certain workforce deliverables, including but not limited to the baseline workforce assessment, survey design, and review of appropriate subsections of data.
Develop training strategy.	

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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

Risk: Given the size and complexity of our network, it may be difficult to quickly gain a thorough understanding of the workforce of our PPS.
Mitigation: We have implemented a comprehensive "Partner Readiness Assessment" in order to quickly gain an understanding of our network and its various workforce capabilities. In addition, we are collaborating with a cross-PPS consortium to contract with a vendor to conduct a cross-PPS workforce analysis that will take into account the overlapping nature of our partner networks.

Risk: Given the rapidly evolving healthcare landscape in New York City, and the challenge of coordinating not only with our hundreds of partners but also with other PPSs with overlapping service areas, the 'Future State' of our workforce will be an evolving target. Indeed, our ability to successfully execute the DSRIP projects will be dependent on coordination and alignment with other PPSs with respect to standardized roles and responsibilities, hiring, and training. This will also require coordination with large partners in multiple PPSs.
Mitigation: We are coordinating with several other PPSs as a consortium to collaborate on a cross-PPS workforce analysis through a common vendor. We also plan to continue to coordinate regularly with other PPSs and large partners in multiple PPSs, to the extent possible, on our collective workforce transformation efforts.

Risk: Given that the entirety of New York State is undertaking this effort concomitantly, demand may exceed supply for certain roles, such as primary care practitioners, care managers, care navigators, etc.
Mitigation: As part of our workforce transformation efforts, we will seek to retrain or redeploy existing PPS employees to the extent possible for care management and navigator positions, and will seek to partner with community-based primary care practices to limit any shortages within our service area.

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.)

Workforce transformation will be dependent on robust practitioner engagement, especially around the redesign of various care models to a patient- and family-centered, population health-driven model of care that will implicate the hiring, re-deployment, and re-training of much of our workforce.

Workforce transformation will also be highly dependent on the clinical and operational plans emerging from project implementation planning, which will identify future state functionalities related to care management and coordination that will drive target-state workforce planning.

Workforce transformation will be dependent on the population health management workstream, especially as it relates to PCMH certification of all

New York City Health and Hospitals Corporation (PPS ID:52)

eligible practices and the related requisite care team retraining and care coordination/management capabilities that will be required.

The funds flow to support workforce transformation will be dependent on the financial analysis and governance provided by the Business Operations & Information Technology Subcommittee.

Finally, workforce transformation will be dependent on adoption of new care management and other related technology systems to support robust population health management capabilities.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Workforce Analysis Vendor	TBD (cross-PPS RFP in process)	Cross-PPS analysis of workforce current state and support in development of target state
Support Infrastructure	PPS Central Services Organization- OneCity Health Services: Christina Jenkins, MD, CEO; Anna Flattau, MD, Chief Clinical Officer; Hub Executive Directors: Nicole Jordan-Martin (Brooklyn), Richard Bernstock (Bronx), Ishmael Carter (Queens), Manhattan Hub Executive Director TBD; Hub Program Managers: Caroline Cross (Manhattan); Rachael Steimnitz (Brooklyn); Erfan Karim (Queens); Lindsay Donald (Bronx)	Working with Workforce Analysis Vendor, develop target workforce state, current state assessment report & gap analysis, workforce transition roadmap, final training strategy, and compensation and benefit analysis report
PPS Governance Leadership	OneCity Health PPS Executive Committee: Ross Wilson, MD, Chair	Approve target workforce state, current state assessment report & gap analysis, workforce transition roadmap, final training strategy, and compensation and benefit analysis report
PPS Governance Entity	OneCity Health Stakeholder & Patient Engagement Subcommittee	Review and recommend target workforce state, current state assessment report & gap analysis, workforce transition roadmap, final training strategy, and compensation and benefit analysis report
PPS Governance Entity	OneCity Health Business Operations & Information Technology Subcommittee	Review and recommend target workforce state, current state assessment report & gap analysis, workforce transition roadmap, final training strategy, and compensation and benefit analysis report
Workforce Training Vendor	1199 and others	Work with Central Services Organization to develop final training strategy and deliver training, as appropriate

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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		
Human Resources stakeholders	PPS Partner HR organizations	Input into workforce transformation planning.
SUNY Downstate	PPS Partners	Participation on PAC and input into workforce transformation planning.
1199 SEIU	PPS Partners	Participation on PAC and input into workforce transformation planning.
CIR/SEIU	PPS Partners	Participation on PAC and input into workforce transformation planning.
DC37	PPS Partners	Participation on PAC and input into workforce transformation planning.
Doctors Council	PPS Partners	Participation on PAC and input into workforce transformation planning.
New York State Nurses Association (NYSNA)	PPS Partners	Participation on PAC and input into workforce transformation planning.
United University Professions (UUP)	PPS Partners	Participation on PAC and input into workforce transformation planning.
Civil Service Employees Association (CSEA)	PPS Partners	Participation on PAC and input into workforce transformation planning.
Public Employees Federation (PEF)	PPS Partners	Participation on PAC and input into workforce transformation planning.
Graduate Student Employee Union	PPS Partners	Participation on PAC and input into workforce transformation planning.
DOHMH	Government agency stakeholder	Coordination on City-wide Workforce Strategy.
External Stakeholders		
Other PPSs	Cross-PPS Coordination Partners	Coordination on City-wide Workforce Strategy.
NYS Dept of Health	Government agency stakeholder	Coordination on City-wide Workforce Strategy.

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.

Learning Management Software: The PPS will require learning management software in order to track training across the PPS.

Partner Management Database and other Workforce Tracking Systems: The PPS will require a robust database to track and manage workforce (and other) related data associated with the PPS partner network. This database will be initially populated through an extensive partner readiness assessment with periodic updates.

IPQR Module 11.9 - Progress Reporting

Instructions :

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

We define success as the development of a comprehensive, PPS-wide workforce strategy that ensures that the PPS workforce of the future has the capacity and skill sets that it needs. Fulfillment of the milestones for this workstream will reflect our progress in collaboratively developing and implementing a robust workforce transformation strategy. The key stakeholders responsible for each core component of the workforce transformation strategy will also ensure that methods are established for data collection and analysis, as well as periodic data reporting.

Success will ultimately be measured by:
- Completion of target workforce state identification
- Completion of current state workforce assessment
- Completion of gap analysis
- Completion of workforce roadmap
- Completion of training strategy
- Number of people retrained
- Number of people redeployed
- Number of people newly hired
- Amount spent on retraining
- Amount spent on redeployment
- Amount spent on new hires

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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**

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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**

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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**

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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**

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 11.11 - IA Monitoring:

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

There are a range of risks to the success of this project. First, many patients will face challenges becoming engaged in their own health care and in prevention activities. To mitigate this risk we intend to work with our partners to identify, engage, and track patients–with special focus on low- and non-utilizers and the uninsured, who represent an opportunity to reduce preventable hospitalizations and ED admissions. Working with CBO partners, we also intend to expand PPS cultural competency and health literacy programs.

Second, the scale and scope of PPS partner support required to meet a number of requirements (e.g., 2014 Level 3 PCMH recognition, connectivity to the RHIO/SHIN-NY) is a risk to meeting the DSRIP DY3 implementation deadline. While many clinics in our PPS eligible to meet NCQA PCMH recognition have already achieved such recognition, it is according to the 2011 standards. In addition, we expect that a number of smaller providers have yet to embark on the PCMH transformation journey. Also, while many within the PPS are using a meaningful use certified EHR, some are not and only some facilities are currently able to share data. We intend to mitigate our health IT and PCMH risks with two main strategies: (1) collaborating closely with IT and PCMH experts within our PPS to determine what support services need to be developed and deployed; (2) prioritizing practices most in need of support, either because they are a priority partner or they are most at risk of not achieving recognition.

Next, the large and diverse service area and population attributed to our PPS could present a risk in terms of meeting a broad range of varying needs across our service area. To mitigate this risk, we have established a governance structure organized into four borough-based hubs, each with a Project Advisory Committee (PAC) and Steering Committee to ensure PPS consistency while enabling responsiveness to local issues and opportunities. With Hub and City-wide members, this structure will enable us to balance local needs with broader population health goals.

We are also concerned about the limited guidance which defines which project requirements apply to different classes of providers. While we made provider speed and scale commitments in our application, this was done without complete information about how the state defined all providers (i.e., all providers to whom project requirements were relevant or all providers). As a result, we believe there is a risk associated with meeting these commitments. To mitigate this risk, we intend to continue to work with the State to identify a solution.

Additionally, our PPS is the predominant public provider in New York City, providing the majority of care to most of the city's Medicaid and uninsured residents. This population is likely to be challenging to engage and is disproportionately affected by social determinants of health. To mitigate this risk, we will undertake a number of strategies, many of which will address similar risks identified as part of other projects. For example, we intend to work with partners that have expertise addressing psycho-social risk factors as part of our ED Care Triage (2.b.iii) and 30-Day Care Transitions (2.b.iv) projects. As part of the "11th Project" (2.d.i), we intend to work closely with CBOs to conduct outreach to hard-to-engage populations.

New York City Health and Hospitals Corporation (PPS ID:52)

Finally, we anticipate a risk in engaging the diverse and large number of providers in our PPS. To mitigate this risk we intend to undertake several strategies: identify clinical champions as needed to build support across the PPS provider network; phase-in certain projects in order to improve the implementation approach and learn best practices related to implementation; and develop and deploy, as needed, assistance to low-performing providers struggling with implementing IDS population health requirements.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 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	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on PPS network capacity and capabilities. Educate partners on PRAT and roll out PRAT.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Analyze current state baseline PRAT data to ensure robust PPS network capacity across all geographies and all components of the care continuum, including medical, behavioral, post-acute (home care, hospice, SNF), long-term care, and community-based service providers.	Project		Completed	07/01/2015	12/30/2015	07/01/2015	12/30/2015	12/31/2015	DY1 Q3
Task Step 3: Incorporate baseline data into partner management database to track all identified partners in the IDS.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 4: Draft Master Services Agreement and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure (collectively, the "Base	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Agreement").									
Task Step 5: Solicit comments from partners.	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 6: Finalize Base Agreement.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 7: Develop and finalize project schedules in concert with Clinical Operational Plans.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Review and negotiate project schedules and budgets with partners in priority order developed by the PPS Executive Committee.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9: Execute agreements with all PPS providers.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 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	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS produces a list of participating HHs and ACOs.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	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	01/01/2016	03/31/2017	01/01/2016	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	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Conduct regular coordination meetings with partnering Health Homes to review outreach/enrollment data, develop collaborative care practices, and share best practices.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Conduct landscape assessment of HHC's ACO population health management systems and capabilities and incorporate findings into partner management database.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: In collaboration with partnering Health Homes, develop approach to determine how Health Homes can augment PPS systems and capabilities to implement the strategy toward	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
evolving into an IDS, including coordination of Health Home referral patterns across the PPS.									
Task Step 4: Use ACO and Health Homes population management tracking ability to report and chart the behavior and care patterns of PPS Health Home and ACO populations.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Integrate ACO and Health Home identifiers with other sub-population identifiers to enable population-level risk stratification.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	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
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 Step 1. Define PPS approach to identify population health and social support needs, including Community Needs Assessments and tactics that address the needs of specific sub-populations such as patients with mental health and/or substance abuse diagnoses.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Identify available community and social supports within geographic areas and create database of these service providers.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3. Establish PPS-wide clinical guidelines and operational	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York City Health and Hospitals Corporation (PPS ID:52)

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
processes for global risk stratification, eligibility criteria for care management services, and minimum set of services to be delivered as part of targeted care management programs, and process for tracking care outside of hospitals. Services for certain sub-populations may include peer support or community-based care navigation.									
Task Step 4. For patients with rising/high risk health/social support needs, develop the minimum elements of a comprehensive care plan to be used with patients which identifies needed health care and community supports, including medical and behavioral health, post-acute care, long-term care and public health services.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 5: For low risk patients, identify process and infrastructure to ensure that information on full scope of support services available by geography is available to providers and accessible by patients	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6. Develop short and long-term training and implementation plan to deploy comprehensive care plans across the PPS, using a phased approach that reflects key IT system interdependencies.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Design and deploy communication strategies to PPS partners, including community-based organizations, to educate providers and patients on available care management and other PPS services.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Using partner management system, identify participating providers lacking Clinically Interoperable Systems and develop plan to address gaps.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Produce report demonstrating that a Clinically Interoperable System is in place for all participating providers.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.									
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	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 Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Operations & Information Technology Subcommittee and approval by Executive Committee.									
Task Step 5: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	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 Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Develop target completion dates for each provider to obtain a certified EHR system.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	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 Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "end state."	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, including training requirements.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Produce report summarizing availability of registry functionality across PPS.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
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.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	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	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Identify cost-effective options to support partners in reaching MU for existing systems or guidance on which MU-certified EMRs are available in the marketplace	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
recognition by the end of DY3, taking into account differing levels of readiness among practices.									
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers (see steps under Requirement #5).	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Conduct periodic assessments of primary care network capacity and access levels using customer relationship management tool and existing survey data measuring patients' perceptions of access levels.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 9: Leverage best practices in operational and process improvement to support practices, as appropriate, in improving access levels.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Contract with Medicaid Managed Care Organizations and other payers, as appropriate, as an integrated system and establish value-based payment arrangements.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Medicaid Managed Care contract(s) are in place that include value-based payments.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine current MCO contracts in place and identify opportunities to expand value-based contracting arrangements across providers and target populations.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop initial plan to expand MCO value-based contracts across the system, identifying priority opportunities, needed infrastructure, reporting requirements and negotiation strategies.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Determine structure of legal entity (or entities) to be created for contracting.	Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Negotiate value-based payment contract with at least one MCO.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 5: Initiate plan to expand value-based payment opportunities for new target populations and with new payers, as appropriate.									
Milestone #9 Establish monthly meetings with Medicaid MCOs to discuss utilization trends, performance issues, and payment reform.	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS holds monthly meetings with Medicaid Managed Care plans to evaluate utilization trends and performance issues and ensure payment reforms are instituted.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify MCOs with which to schedule monthly progress meetings, using existing MCO penetration among PPS attributed lives as a key identification criteria.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Identify any standing agenda items and key metrics that will be reviewed in monthly meetings.	Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Launch series of regular monthly meetings, using initial meetings to identify key short and long-term objectives of meeting structure.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	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	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Providers receive incentive-based compensation consistent with DSRIP goals and objectives.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify current value-based compensation models used in the PPS.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Define universe of relevant outcome measures in alignment with Medicaid MCO, HARP, and DOH requirements.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Develop provider incentive-based compensation model(s) across PPS clinical programs that reward achievement	Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
of patient outcomes.									
Task Step 4: Solicit feedback on model(s) from key stakeholders; review and consensus-driven recommendation of model(s) by Business Operations & Information Technology Subcommittee and Care Models Subcommittee.	Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Through Stakeholder Engagement Committee, develop communication plan that addresses the needs of providers across key care settings (e.g., PCMH, mental health providers). Solicit feedback on plan from key stakeholders.	Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Pilot and evaluate new incentive-based compensation models and develop plan for broader roll-out.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Community health workers and community-based organizations utilized in IDS for outreach and navigation activities.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop objectives and components of the community outreach plan to achieve patient engagement with the PPS, taking into account the unique community needs and network capacity within each Hub.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Conduct assessment of current resources in the community, by Hub.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3. Identify the timing, resource requirements and culturally-competent expertise to launch the community outreach plan.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Implement the community outreach plan, within the context of the PPS care management and patient engagement strategies.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Develop and implement tools to track, on an on-going	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
basis, levels of community engagement and identify priority areas for further engagement efforts by the PPS.									

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 All PPS providers must be included in the Integrated Delivery System. The IDS should include all medical, behavioral, post-acute, long-term care, and community-based service providers within the PPS network; additionally, the IDS structure must include payers and social service organizations, as necessary to support its strategy.										
Task PPS includes continuum of providers in IDS, including medical, behavioral health, post-acute, long-term care, and community-based providers.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on PPS network capacity and capabilities. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline PRAT data to ensure robust PPS network capacity across all geographies and all components of the care continuum, including medical, behavioral, post-acute (home care, hospice, SNF), long-term care, and community-based service providers.										
Task Step 3: Incorporate baseline data into partner management database to track all identified partners in the IDS.										
Task Step 4: Draft Master Services Agreement and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure (collectively, the "Base Agreement").										
Task Step 5: Solicit comments from partners.										
Task Step 6: Finalize Base Agreement.										
Task Step 7: Develop and finalize project schedules in concert with										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Clinical Operational Plans.										
Task Step 8: Review and negotiate project schedules and budgets with partners in priority order developed by the PPS Executive Committee.										
Task Step 9: Execute agreements with all PPS providers.										
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 Step 1: Conduct regular coordination meetings with partnering Health Homes to review outreach/enrollment data, develop collaborative care practices, and share best practices.										
Task Step 2: Conduct landscape assessment of HHC's ACO population health management systems and capabilities and incorporate findings into partner management database.										
Task Step 3: In collaboration with partnering Health Homes, develop approach to determine how Health Homes can augment PPS systems and capabilities to implement the strategy toward evolving into an IDS, including coordination of Health Home referral patterns across the PPS.										
Task Step 4: Use ACO and Health Homes population management tracking ability to report and chart the behavior and care patterns of PPS Health Home and ACO populations.										
Task Step 5: Integrate ACO and Health Home identifiers with other sub-population identifiers to enable population-level risk stratification.										
Milestone #3 Ensure patients receive appropriate health care and community										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
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 Step 1. Define PPS approach to identify population health and social support needs, including Community Needs Assessments and tactics that address the needs of specific sub-populations such as patients with mental health and/or substance abuse diagnoses.										
Task Step 2: Identify available community and social supports within geographic areas and create database of these service providers.										
Task Step 3. Establish PPS-wide clinical guidelines and operational processes for global risk stratification, eligibility criteria for care management services, and minimum set of services to be delivered as part of targeted care management programs, and process for tracking care outside of hospitals. Services for certain sub-populations may include peer support or community-based care navigation.										
Task Step 4. For patients with rising/high risk health/social support needs, develop the minimum elements of a comprehensive care plan to be used with patients which identifies needed health care and community supports, including medical and behavioral health, post-acute care, long-term care and public health services.										
Task Step 5: For low risk patients, identify process and infrastructure to ensure that information on full scope of support services available by geography is available to providers and accessible by patients										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 6. Develop short and long-term training and implementation plan to deploy comprehensive care plans across the PPS, using a phased approach that reflects key IT system interdependencies.										
Task Step 7: Design and deploy communication strategies to PPS partners, including community-based organizations, to educate providers and patients on available care management and other PPS services.										
Task Step 8: Using partner management system, identify participating providers lacking Clinically Interoperable Systems and develop plan to address gaps.										
Task Step 9: Produce report demonstrating that a Clinically Interoperable System is in place for all participating providers.										
Milestone #4 Ensure that all PPS safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including directed exchange (secure messaging), alerts and patient record look up, by the end of Demonstration Year (DY) 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	44	110	220
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	56	141	282
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	2	5	10
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	20	50	99
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	6	16	32
Task PPS uses alerts and secure messaging functionality.										
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
clinical partners.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.										
Task Step 3: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.										
Task Step 4: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.										
Task Step 5: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.										
Task Step 6: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.										
Task Step 7: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.										
Milestone #5 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of Demonstration Year 3.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	44	110	220
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.										
Task Step 2: Identify cost-effective options to support clinical partners										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.										
Task Step 3: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.										
Task Step 4: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.										
Task Step 5: Develop target completion dates for each provider to obtain a certified EHR system.										
Task Step 6: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.										
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 Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.										
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "end state."										
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, including training requirements.										
Task Step 4: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 5: Produce report summarizing availability of registry functionality across PPS.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 #7 Achieve 2014 Level 3 PCMH primary care certification and/or meet state-determined criteria for Advanced Primary Care Models for all participating PCPs, expand access to primary care providers, and meet EHR Meaningful Use standards by the end of DY 3.										
Task Primary care capacity increases improved access for patients seeking services - particularly in high-need areas.										
Task All practices meet 2014 NCQA Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	126	316	632
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 Step 1: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 2: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps										
Task Step 3: Identify cost-effective options to support partners in reaching MU for existing systems or guidance on which MU-certified EMRs are available in the marketplace										
Task Step 4: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										
Task Step 5: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.										
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan,										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
including progress against plan to ensure certified EHRs are in place for all eligible providers (see steps under Requirement #5).										
Task Step 8: Conduct periodic assessments of primary care network capacity and access levels using customer relationship management tool and existing survey data measuring patients' perceptions of access levels.										
Task Step 9: Leverage best practices in operational and process improvement to support practices, as appropriate, in improving access levels.										
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 Step 1: Determine current MCO contracts in place and identify opportunities to expand value-based contracting arrangements across providers and target populations.										
Task Step 2: Develop initial plan to expand MCO value-based contracts across the system, identifying priority opportunities, needed infrastructure, reporting requirements and negotiation strategies.										
Task Step 3: Determine structure of legal entity (or entities) to be created for contracting.										
Task Step 4: Negotiate value-based payment contract with at least one MCO.										
Task Step 5: Initiate plan to expand value-based payment opportunities for new target populations and with new payers, as appropriate.										
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.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Identify MCOs with which to schedule monthly progress meetings, using existing MCO penetration among PPS attributed lives as a key identification criteria.										
Task Step 2: Identify any standing agenda items and key metrics that will be reviewed in monthly meetings.										
Task Step 3: Launch series of regular monthly meetings, using initial meetings to identify key short and long-term objectives of meeting structure.										
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 Step 1: Identify current value-based compensation models used in the PPS.										
Task Step 2: Define universe of relevant outcome measures in alignment with Medicaid MCO, HARP, and DOH requirements.										
Task Step 3: Develop provider incentive-based compensation model(s) across PPS clinical programs that reward achievement of patient outcomes.										
Task Step 4: Solicit feedback on model(s) from key stakeholders; review and consensus-driven recommendation of model(s) by Business Operations & Information Technology Subcommittee and Care Models Subcommittee.										
Task Step 5: Through Stakeholder Engagement Committee, develop communication plan that addresses the needs of providers across key care settings (e.g., PCMH, mental health providers). Solicit feedback on plan from key stakeholders.										
Task Step 6: Pilot and evaluate new incentive-based compensation models and develop plan for broader roll-out.										
Milestone #11 Engage patients in the integrated delivery system through										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
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 Step 1: Develop objectives and components of the community outreach plan to achieve patient engagement with the PPS, taking into account the unique community needs and network capacity within each Hub.										
Task Step 2: Conduct assessment of current resources in the community, by Hub.										
Task Step 3. Identify the timing, resource requirements and culturally-competent expertise to launch the community outreach plan.										
Task Step 4: Implement the community outreach plan, within the context of the PPS care management and patient engagement strategies.										
Task Step 5: Develop and implement tools to track, on an on-going basis, levels of community engagement and identify priority areas for further engagement efforts by the PPS.										

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 Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on PPS network capacity and capabilities.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline PRAT data to ensure robust PPS network capacity across all geographies and all components of the care continuum, including medical, behavioral, post-acute (home care, hospice, SNF), long-term care, and community-based service providers.										
Task Step 3: Incorporate baseline data into partner management database to track all identified partners in the IDS.										
Task Step 4: Draft Master Services Agreement and exhibits, which will describe legal terms and conditions of partner participation in the PPS and governance structure (collectively, the "Base Agreement").										
Task Step 5: Solicit comments from partners.										
Task Step 6: Finalize Base Agreement.										
Task Step 7: Develop and finalize project schedules in concert with Clinical Operational Plans.										
Task Step 8: Review and negotiate project schedules and budgets with partners in priority order developed by the PPS Executive Committee.										
Task Step 9: Execute agreements with all PPS providers.										
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 Step 1: Conduct regular coordination meetings with partnering Health Homes to review outreach/enrollment data, develop										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
collaborative care practices, and share best practices.										
Task Step 2: Conduct landscape assessment of HHC's ACO population health management systems and capabilities and incorporate findings into partner management database.										
Task Step 3: In collaboration with partnering Health Homes, develop approach to determine how Health Homes can augment PPS systems and capabilities to implement the strategy toward evolving into an IDS, including coordination of Health Home referral patterns across the PPS.										
Task Step 4: Use ACO and Health Homes population management tracking ability to report and chart the behavior and care patterns of PPS Health Home and ACO populations.										
Task Step 5: Integrate ACO and Health Home identifiers with other sub-population identifiers to enable population-level risk stratification.										
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 Step 1. Define PPS approach to identify population health and social support needs, including Community Needs Assessments and tactics that address the needs of specific sub-populations such as patients with mental health and/or substance abuse diagnoses.										
Task Step 2: Identify available community and social supports within										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
geographic areas and create database of these service providers.										
Task Step 3. Establish PPS-wide clinical guidelines and operational processes for global risk stratification, eligibility criteria for care management services, and minimum set of services to be delivered as part of targeted care management programs, and process for tracking care outside of hospitals. Services for certain sub-populations may include peer support or community-based care navigation.										
Task Step 4. For patients with rising/high risk health/social support needs, develop the minimum elements of a comprehensive care plan to be used with patients which identifies needed health care and community supports, including medical and behavioral health, post-acute care, long-term care and public health services.										
Task Step 5: For low risk patients, identify process and infrastructure to ensure that information on full scope of support services available by geography is available to providers and accessible by patients										
Task Step 6. Develop short and long-term training and implementation plan to deploy comprehensive care plans across the PPS, using a phased approach that reflects key IT system interdependencies.										
Task Step 7: Design and deploy communication strategies to PPS partners, including community-based organizations, to educate providers and patients on available care management and other PPS services.										
Task Step 8: Using partner management system, identify participating providers lacking Clinically Interoperable Systems and develop plan to address gaps.										
Task Step 9: Produce report demonstrating that a Clinically Interoperable System is in place for all participating providers.										
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										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Demonstration Year (DY) 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	329	439	439	439	439	439	439	439	439	439
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	423	564	564	564	564	564	564	564	564	564
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	14	19	19	19	19	19	19	19	19	19
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	149	198	198	198	198	198	198	198	198	198
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	48	64	64	64	64	64	64	64	64	64
Task PPS uses alerts and secure messaging functionality.										
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.										
Task Step 3: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.										
Task Step 4: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.										
Task Step 5: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.										
Task Step 6: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or										

New York City Health and Hospitals Corporation (PPS ID:52)

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
third party assistance programs.										
Task Step 7: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.										
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.	329	439	439	439	439	439	439	439	439	439
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.										
Task Step 3: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.										
Task Step 4: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.										
Task Step 5: Develop target completion dates for each provider to obtain a certified EHR system.										
Task Step 6: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.										
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.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.										
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "end state."										
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, including training requirements.										
Task Step 4: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 5: Produce report summarizing availability of registry functionality across PPS.										
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.	947	1,263	1,263	1,263	1,263	1,263	1,263	1,263	1,263	1,263
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 Step 1: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 2: Conduct a gap analysis by key PCMH care model										

New York City Health and Hospitals Corporation (PPS ID:52)

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
domain across eligible practices and determine cost and feasibility of closing gaps										
Task Step 3: Identify cost-effective options to support partners in reaching MU for existing systems or guidance on which MU-certified EMRs are available in the marketplace										
Task Step 4: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										
Task Step 5: Coordinate with other PPSs in overlapping service areas, such as Community Care Brooklyn, and Bronx Partners for Healthy Communities, to develop strategies for shared partners.										
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers (see steps under Requirement #5).										
Task Step 8: Conduct periodic assessments of primary care network capacity and access levels using customer relationship management tool and existing survey data measuring patients' perceptions of access levels.										
Task Step 9: Leverage best practices in operational and process improvement to support practices, as appropriate, in improving access levels.										
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 Step 1: Determine current MCO contracts in place and identify opportunities to expand value-based contracting arrangements across providers and target populations.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Develop initial plan to expand MCO value-based contracts across the system, identifying priority opportunities, needed infrastructure, reporting requirements and negotiation strategies.										
Task Step 3: Determine structure of legal entity (or entities) to be created for contracting.										
Task Step 4: Negotiate value-based payment contract with at least one MCO.										
Task Step 5: Initiate plan to expand value-based payment opportunities for new target populations and with new payers, as appropriate.										
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 Step 1: Identify MCOs with which to schedule monthly progress meetings, using existing MCO penetration among PPS attributed lives as a key identification criteria.										
Task Step 2: Identify any standing agenda items and key metrics that will be reviewed in monthly meetings.										
Task Step 3: Launch series of regular monthly meetings, using initial meetings to identify key short and long-term objectives of meeting structure.										
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 Step 1: Identify current value-based compensation models used in the PPS.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Define universe of relevant outcome measures in alignment with Medicaid MCO, HARP, and DOH requirements.										
Task Step 3: Develop provider incentive-based compensation model(s) across PPS clinical programs that reward achievement of patient outcomes.										
Task Step 4: Solicit feedback on model(s) from key stakeholders; review and consensus-driven recommendation of model(s) by Business Operations & Information Technology Subcommittee and Care Models Subcommittee.										
Task Step 5: Through Stakeholder Engagement Committee, develop communication plan that addresses the needs of providers across key care settings (e.g., PCMH, mental health providers). Solicit feedback on plan from key stakeholders.										
Task Step 6: Pilot and evaluate new incentive-based compensation models and develop plan for broader roll-out.										
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 Step 1: Develop objectives and components of the community outreach plan to achieve patient engagement with the PPS, taking into account the unique community needs and network capacity within each Hub.										
Task Step 2: Conduct assessment of current resources in the community, by Hub.										
Task Step 3. Identify the timing, resource requirements and culturally-competent expertise to launch the community outreach plan.										
Task Step 4: Implement the community outreach plan, within the context of the PPS care management and patient engagement strategies.										
Task Step 5: Develop and implement tools to track, on an on-going										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
basis, levels of community engagement and identify priority areas for further engagement efforts by the PPS.										

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.	
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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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	
Milestone #6	Pass & Ongoing	
Milestone #7	Pass & Ongoing	
Milestone #8	Pass & Ongoing	
Milestone #9	Pass & Ongoing	
Milestone #10	Pass & Ongoing	
Milestone #11	Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

Instructions :

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

We anticipate that a significant risk facing the PPS is the fragmented set of care management programs available to populations attributed to the PPS. The programs have different and often overlapping populations, program structures, staffing models, and services. To mitigate this risk, our PPS is in the midst of developing an integrated care management strategy which will engage representatives from OneCity Health partnership, including HHC, primary care practices, Health Homes, and MCOs. The goal will be to understand how various care management programs work in concert with one another and to determine optimal approaches to coordination. This includes the development of standard policies, procedures, care pathways and clinical protocols related to care transitions, referral management, team-based care, and data sharing and reporting.

Another risk related to care management is the challenge associated with recruiting and training sufficient care management staff of various types and levels. To mitigate this risk, our PPS intends to work with partners to identify a pipeline of care management staff. We also intend to contract with organizations with expertise in workforce training (1199 SEIU Training and Employment Funds, SUNY Downstate Medical Center, and others) to ensure that care management staff are adequately trained.

We have also identified risks related to identification of and outreach to the target population. Based on the PPS's experience with Medicaid Health Homes and the lead applicant's experience with its Medicare Shared Savings Program activities, we anticipate that some members of the attributed population will be difficult to locate and may also be challenging to engage. To mitigate this risk, we anticipate leveraging the wealth of local knowledge and on-the-ground expertise represented by the diverse group of community-based partners within the OneCity Health PPS. We believe community-based organizations may be best-positioned to locate and outreach to some populations given this knowledge and experience.

Finally, the scale and scope of PPS partner support required to achieve 2014 Level 3 PCMH recognition is a risk to meeting the DSRIP DY3 implementation deadline. While many clinics within our PPS that are eligible to meet NCQA PCMH recognition have already achieved such recognition, it is according to the 2011 standards. In addition, we know from early partner survey data that a number of smaller providers have yet to embark on the PCMH transformation journey. We intend to mitigate this risk with two main strategies: first, we are collaborating closely with IT and PCMH experts within our PPS to determine what support services need to be developed and deployed. Second, we will prioritize practices most in need of support, either because the partner is integral to successful implementation (e.g., services impact a relatively high number of patients) or they are most at risk of not achieving recognition.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY4,Q4	63,479

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
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
nholder9	Baseline or Performance Documentation	52_PMDL2215_1_3_20160125134016_OneCity_Health_Patient_Engagement_Commitments.pdf	Please see page 1 with the patient engagement speed commitments for this project, which begin in DY2 Q1.	01/25/2016 01:40 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Assess current baseline of care coordination programs in PPS.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Design target state for a Health Home At-Risk Intervention Program. Refine as necessary. Coordinate with collaborating PPSs, as appropriate.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Develop a Health Home At-Risk Intervention Program, leveraging current PPS resources. Modify or update program on the basis of new patient evidence or newly-endorsed best practices.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Obtain input on Program from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Review and consensus-driven recommendation on Program by Care Models Subcommittee. Validate Program with other relevant stakeholders, as needed.	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Launch and rollout Health Home At-Risk Intervention Program.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	Project	N/A	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Conduct periodic assessments of true and usable primary care network capacity and access levels using customer relationship management tool and existing survey data measuring patients' perceptions of access levels.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 7: Leverage best practices in operational and process	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
improvement to support practices, as appropriate, in improving access levels.									
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	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 Case Management / Health 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 Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	Project	N/A	In Progress	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 Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Develop target completion dates for each provider to obtain a certified EHR system.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "target state."	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, including training requirements.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Produce report summarizing availability of registry functionality across PPS.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Procedures to engage at-risk patients with care management plan instituted.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for care management plans.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize PPS-wide guidelines and obtain input from	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York City Health and Hospitals Corporation (PPS ID:52)

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
PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.									
Task Step 3: Review and consensus-driven recommendation of PPS-wide guidelines by Care Models Subcommittee.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine care management plan guidelines through Hub-based planning process.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Monitor use of care management plans and refine guidelines as necessary.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Each identified PCP establish partnerships with the local Health Home for care management services.	Provider	Case Management / Health Home	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Educate partners and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Analyze current state baseline to assess existing care management capabilities and primary care resources.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Identify care management roles, responsibilities, and processes for primary care providers and health home organizations	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Engage in contracting process with primary care and health home partners; contracts will reflect the roles, responsibilities, and processes outlined in Step 4.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 6: Rollout and monitor performance of care management services.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has established partnerships to medical, behavioral health, and social services.	Provider	Case Management / Health Home	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Educate partners and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Analyze current state baseline to assess network resources.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Educate primary care provider partners on network resources. Develop and publish a sortable listing of network services; periodically refresh listing as network develops.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 6: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.									
Task Step 7: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 8: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 9: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 10: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York City Health and Hospitals Corporation (PPS ID:52)

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
guidelines for addressing risk factor reduction and ensuring appropriate management of chronic diseases and BH/SUD comorbidities.									
Task Step 2: Synthesize PPS-wide guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Review and consensus-driven recommendation of PPS-wide guidelines by Care Models Subcommittee.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine care management plan guidelines through Hub-based planning process.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Monitor use of care management plans and refine guidelines as necessary.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Define training needs around risk factor reduction and chronic disease management.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Develop educational materials that are culturally and linguistically appropriate.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8: Identify training resources available and create a culturally and linguistically sensitive training plan around risk factor reduction and chronic disease management.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Launch and roll out training program.	Project		In Progress	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 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.										
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
definition of roles of PCMH/APC PCPs and HHs										
Task Step 1: Assess current baseline of care coordination programs in PPS.										
Task Step 2: Design target state for a Health Home At-Risk Intervention Program. Refine as necessary. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Develop a Health Home At-Risk Intervention Program, leveraging current PPS resources. Modify or update program on the basis of new patient evidence or newly-endorsed best practices.										
Task Step 4: Obtain input on Program from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Review and consensus-driven recommendation on Program by Care Models Subcommittee. Validate Program with other relevant stakeholders, as needed.										
Task Step 5: Launch and rollout Health Home At-Risk Intervention Program.										
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	0	0	0	0	0	0	0	82	205	411
Task Step 1: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 2: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.										
Task Step 3: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										
Task Step 5: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.										
Task Step 6: Conduct periodic assessments of true and usable primary care network capacity and access levels using customer relationship management tool and existing survey data measuring patients' perceptions of access levels.										
Task Step 7: Leverage best practices in operational and process improvement to support practices, as appropriate, in improving access levels.										
Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	29	71	143
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	3	7	14
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	2	4	9
Task PPS uses alerts and secure messaging functionality.										
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
with local HIE/RHIO/SHIN-NY.										
Task Step 3: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.										
Task Step 4: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.										
Task Step 5: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.										
Task Step 6: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria).										
Task PPS has achieved NCQA 2014 Level 3 PCMH standards and/or APCM.	0	0	0	0	0	0	0	29	71	143
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.										
Task Step 3: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.										
Task Step 4: Develop target completion dates for each provider to										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
obtain a certified EHR system.										
Task Step 5: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.										
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.										
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "target state."										
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, including training requirements.										
Task Step 4: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 5: Produce report summarizing availability of registry functionality across PPS.										
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.										
Task Procedures to engage at-risk patients with care management plan instituted.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for care management plans.										
Task Step 2: Synthesize PPS-wide guidelines and obtain input from										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Review and consensus-driven recommendation of PPS-wide guidelines by Care Models Subcommittee.										
Task Step 4: Refine care management plan guidelines through Hub-based planning process.										
Task Step 5: Monitor use of care management plans and refine guidelines as necessary.										
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	0	0	0	0	205	411	821	821	821
Task Each identified PCP establish partnerships with the local Health Home for care management services.	0	0	0	0	0	9	19	37	37	37
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Educate partners and roll out PRAT.										
Task Step 3: Analyze current state baseline to assess existing care management capabilities and primary care resources.										
Task Step 4: Identify care management roles, responsibilities, and processes for primary care providers and health home organizations										
Task Step 5: Engage in contracting process with primary care and health home partners; contracts will reflect the roles, responsibilities, and processes outlined in Step 4.										
Task Step 6: Rollout and monitor performance of care management services.										
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).										
Task PPS has established partnerships to medical, behavioral health, and social services.	0	0	0	0	0	205	411	821	821	821
Task PPS has established partnerships to medical, behavioral health, and social services.	0	0	0	0	0	9	19	37	37	37
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Educate partners and roll out PRAT.										
Task Step 3: Analyze current state baseline to assess network resources.										
Task Step 4: Educate primary care provider partners on network resources. Develop and publish a sortable listing of network services; periodically refresh listing as network develops.										
Task Step 5: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.										
Task Step 6: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.										
Task Step 7: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.										
Task Step 8: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 9: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.										
Task Step 10: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.										
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.										
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.										
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.										
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.										
Task Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for addressing risk factor reduction and ensuring appropriate management of chronic diseases and BH/SUD comorbidities.										
Task Step 2: Synthesize PPS-wide guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Review and consensus-driven recommendation of PPS-wide guidelines by Care Models Subcommittee.										
Task Step 4: Refine care management plan guidelines through Hub-based planning process.										
Task Step 5: Monitor use of care management plans and refine guidelines as necessary.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 6: Define training needs around risk factor reduction and chronic disease management.										
Task Step 7: Develop educational materials that are culturally and linguistically appropriate.										
Task Step 8: Identify training resources available and create a culturally and linguistically sensitive training plan around risk factor reduction and chronic disease management.										
Task Step 9: Launch and roll out training program.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.										
Task A clear strategic plan is in place which includes, at a minimum: - Definition of the Health Home At-Risk Intervention Program - Development of comprehensive care management plan, with definition of roles of PCMH/APC PCPs and HHs										
Task Step 1: Assess current baseline of care coordination programs in PPS.										
Task Step 2: Design target state for a Health Home At-Risk Intervention Program. Refine as necessary. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Develop a Health Home At-Risk Intervention Program, leveraging current PPS resources. Modify or update program on the basis of new patient evidence or newly-endorsed best practices.										
Task Step 4: Obtain input on Program from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Review and consensus-driven recommendation on Program by Care Models Subcommittee. Validate Program with other relevant stakeholders, as needed.										
Task Step 5: Launch and rollout Health Home At-Risk Intervention										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Program.										
Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and APCM standards	616	821	821	821	821	821	821	821	821	821
Task Step 1: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 2: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.										
Task Step 3: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										
Task Step 4: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										
Task Step 5: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.										
Task Step 6: Conduct periodic assessments of true and usable primary care network capacity and access levels using customer relationship management tool and existing survey data measuring patients' perceptions of access levels.										
Task Step 7: Leverage best practices in operational and process improvement to support practices, as appropriate, in improving access levels.										
Milestone #3 Ensure that all participating safety net providers are actively										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	214	285	285	285	285	285	285	285	285	285
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	21	28	28	28	28	28	28	28	28	28
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	13	17	17	17	17	17	17	17	17	17
Task PPS uses alerts and secure messaging functionality.										
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.										
Task Step 3: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.										
Task Step 4: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.										
Task Step 5: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.										
Task Step 6: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.										
Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task EHR meets 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.	214	285	285	285	285	285	285	285	285	285
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.										
Task Step 3: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.										
Task Step 4: Develop target completion dates for each provider to obtain a certified EHR system.										
Task Step 5: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.										
Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.										
Task PPS identifies targeted patients through patient registries and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.										
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "target state."										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, including training requirements.										
Task Step 4: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 5: Produce report summarizing availability of registry functionality across PPS.										
Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.										
Task Procedures to engage at-risk patients with care management plan instituted.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for care management plans.										
Task Step 2: Synthesize PPS-wide guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Review and consensus-driven recommendation of PPS-wide guidelines by Care Models Subcommittee.										
Task Step 4: Refine care management plan guidelines through Hub-based planning process.										
Task Step 5: Monitor use of care management plans and refine guidelines as necessary.										
Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.										
Task Each identified PCP establish partnerships with the local Health Home for care management services.	821	821	821	821	821	821	821	821	821	821
Task Each identified PCP establish partnerships with the local Health Home for care management services.	37	37	37	37	37	37	37	37	37	37
Task										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Educate partners and roll out PRAT.										
Task Step 3: Analyze current state baseline to assess existing care management capabilities and primary care resources.										
Task Step 4: Identify care management roles, responsibilities, and processes for primary care providers and health home organizations										
Task Step 5: Engage in contracting process with primary care and health home partners; contracts will reflect the roles, responsibilities, and processes outlined in Step 4.										
Task Step 6: Rollout and monitor performance of care management services.										
Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).										
Task PPS has established partnerships to medical, behavioral health, and social services.	821	821	821	821	821	821	821	821	821	821
Task PPS has established partnerships to medical, behavioral health, and social services.	37	37	37	37	37	37	37	37	37	37
Task PPS uses EHRs and HIE system to facilitate and document partnerships with needed services.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Educate partners and roll out PRAT.										
Task Step 3: Analyze current state baseline to assess network resources.										
Task										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 4: Educate primary care provider partners on network resources. Develop and publish a sortable listing of network services; periodically refresh listing as network develops.										
Task Step 5: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.										
Task Step 6: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.										
Task Step 7: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.										
Task Step 8: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.										
Task Step 9: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.										
Task Step 10: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.										
Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.										
Task PPS has adopted evidence-based practice guidelines for management of chronic conditions. Chronic condition appropriate evidence-based practice guidelines developed and process implemented.										
Task Regularly scheduled formal meetings are held to develop collaborative evidence-based care practices.										
Task PPS has included social services agencies in development of risk reduction and care practice guidelines.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Culturally-competent educational materials have been developed to promote management and prevention of chronic diseases.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for addressing risk factor reduction and ensuring appropriate management of chronic diseases and BH/SUD comorbidities.										
Task Step 2: Synthesize PPS-wide guidelines and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Review and consensus-driven recommendation of PPS-wide guidelines by Care Models Subcommittee.										
Task Step 4: Refine care management plan guidelines through Hub-based planning process.										
Task Step 5: Monitor use of care management plans and refine guidelines as necessary.										
Task Step 6: Define training needs around risk factor reduction and chronic disease management.										
Task Step 7: Develop educational materials that are culturally and linguistically appropriate.										
Task Step 8: Identify training resources available and create a culturally and linguistically sensitive training plan around risk factor reduction and chronic disease management.										
Task Step 9: Launch and roll out training program.										

Prescribed Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	
Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	
Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	
Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	
Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	
Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	
Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	
Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

One risk to successful implementation of the ED Care Triage project is overwhelming the 6 HHC hospitals that are already implementing the Center for Medicare and Medicaid Innovation (CMMI) Preventing Avoidable ED/Inpatient Use project. In addition, there is a risk of presenting guidance to these facilities that may come into conflict with or contradict CMS-approved protocols developed for the CMMI project. To address these risks, we will use a staged implementation, focusing first on hospitals that are not implementing the CMMI grant. In these hospitals we will implement the same ED Care Management components as those CMMI-funded hospitals. Once CMMI funding has ended, we will identify potential enhancements for those hospitals, such as supplementary care management and ambulatory support tools developed under DSRIP.

We have identified several risks related to primary care linkages and access. One challenge may be limited capacity at primary care clinics that hinder timely appointments. This challenge will be mitigated by one or more of the following strategies: increased staffing, increased hours provided at facilities, and coordination of primary care capacity across the PPS. To increase network capacity, we will work with appropriate partners, including federally qualified health centers (FQHCs) and community providers, to coordinate a system of extended hours and improved open access capabilities. Another risk is in meeting the project requirement around making PCP appointments for patients in the ED. First, we anticipate challenges in identifying the true or usable primary care capacity of partners, particular during evenings and weekends. Second, we are concerned that patients may not show up for appointments, which both reduces capacity and also means the patient may not get the care they need. Finally, the process of making appointments may take significant staff time. To address these risks, we intend to develop an approach to determining capacity both within HHC facilities as well as among other partners. This approach will identify technology and workflow requirements. To address concerns about no shows, we will leverage care managers to follow-up with patients about the need for and value of primary care visits. Care managers, community health workers and other staff can also identify barriers to keeping appointments (e.g., transportation), and identify resources to help patients overcome those barriers. Finally, we will take a data-driven approach to determining the optimal workflow for ED appointment making and determine where improvements may be needed.

Another risk we anticipate is in meeting the needs of particularly complex patients, such as those who are homeless. To mitigate this risk, we intend to work closely with partners with expertise in addressing psycho-social risk factors to better inform the care team of options for these patients and to address operational and/or staffing issues that impede their access to follow-up care.

Finally, the health IT capabilities required to be successful in this project present a risk. Many aspects of our ED Care Triage proposed interventions rely on enhanced IT systems to support: (1) population health management capabilities; (2) functional capabilities to support operations and measure performance; (3) care coordination and management capabilities; (4) improved connectivity within the PPS and with partners, including assistance with meeting Stage 2 Meaningful Use attestation; and, (5) health information exchange (HIE) with RHIO/SHIN-NY and private HIE. To mitigate this risk we intend to: focus on augmenting existing IT capabilities; prioritize partners that are key to being successful within this project; and, identifying the technology and implementation support services that are critical to success.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	54,394

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
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
nholder9	Baseline or Performance Documentation	52_PMDL2715_1_3_20160125133623_OneCity_Health_Patient_Engagement_Commitments.pdf	Please see page 2 for the patient engagement commitments for this project which begin DY2 Q1.	01/25/2016 01:39 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Stand up program based on project requirements	Project		In Progress	04/01/2015	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Convene Clinical Leadership Team to define initial PPS-wide guidelines for ED care triage program, including BH/SUD considerations. Synthesize guidelines and protocols. Refine over time.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on guidelines for ED care triage program. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on ED care triage guidelines and protocols.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine ED care triage program guidelines.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Monitor roll-out of guidelines and refine as needed.	Project		In Progress	04/01/2016	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 Q2
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	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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 providers. c. Ensure real time notification to a Health Home care manager as applicable									
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	Provider	Safety Net Hospital	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on true and usable primary care capacity and access across the PPS service area. Educate partners on PRAT and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess existing primary care capacity and access. Segment providers.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes for effective partnerships between EDs and primary care providers.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Contract with partners who intend to participate in this project, including, if applicable, community based behavioral health organizations.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 5: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 6: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.									
Task Step 7: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 10: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 11: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 12: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 13: Develop target completion dates for each provider to obtain a certified EHR system.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 14: Establish reporting process to track progress of third party resource in overseeing implementation and training with	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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
relevant PPS partners.									
Task Step 15: Assess current baseline of PCP offices and EDs with encounter notification system (ENS) installed.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 16: Design and refine target state for installation and use of ENS.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 17: Develop plan for installation of ENS in PCP offices and EDs, as laid out in target state.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 18: Validate with PPS governance bodies and relevant stakeholders, as needed.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 19: Launch and roll out plan for installation of ENS in PCP offices and EDs.	Project		In Progress	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Project	N/A	In Progress	04/01/2015	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 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	09/30/2018	04/01/2015	09/30/2018	09/30/2018	DY4 Q2
Task Step 1: Convene Clinical Leadership Team to define PPS-wide protocols for connecting patients to non-emergency PCP and needed community support resources. Synthesize guidelines.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on protocols for connecting patients to non-emergency PCP & community support	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York City Health and Hospitals Corporation (PPS ID:52)

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
resources. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.									
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on protocols for connecting patients to non-emergency PCP & community support resources.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine protocols for connecting patients to non-emergency PCP & community support.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs on protocols for connecting patients to non-emergency PCP & community support.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Develop curriculum for training on connecting patients to non-emergency PCP & community support; identify training resources and create training plan.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Launch and roll out training program.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Monitor roll out of protocols and refine as needed.	Project		In Progress	04/01/2016	09/30/2018	04/01/2016	09/30/2018	09/30/2018	DY4 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	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	Provider	Safety Net Hospital	On Hold	04/01/2015	03/31/2020	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Coordination and Management Solution (CCMS) and related registries.									
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll out training program on interim tracking process.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Monitor implementation of interim tracking process and refine as needed.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, and incorporate user documentation feedback.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Develop CCMS training requirements.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
training.									

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 Step 1: Convene Clinical Leadership Team to define initial PPS-wide guidelines for ED care triage program, including BH/SUD considerations. Synthesize guidelines and protocols. Refine over time.										
Task Step 2: Obtain input from PAC on guidelines for ED care triage program. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on ED care triage guidelines and protocols.										
Task Step 4: Through Hub-based planning process, refine ED care triage program guidelines.										
Task Step 5: Monitor roll-out of guidelines and refine as needed.										
Milestone #2 Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	0	0	0	0	0	0	0	29	71	143

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 meets Meaningful Use Stage 2 CMS requirements (Note: any/all MU requirements adjusted by CMS will be incorporated into the assessment criteria.)										
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	0	0	29	71	143
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	0	0	0	0	0	0	0	1	3	6
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on true and usable primary care capacity and access across the PPS service area. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess existing primary care capacity and access. Segment providers.										
Task Step 3: Identify roles, responsibilities, and processes for effective partnerships between EDs and primary care providers.										
Task Step 4: Contract with partners who intend to participate in this project, including, if applicable, community based behavioral health organizations.										
Task Step 5: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 6: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.										
Task Step 7: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										
Task Step 8: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 9: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.										
Task Step 10: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.										
Task Step 11: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.										
Task Step 12: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.										
Task Step 13: Develop target completion dates for each provider to obtain a certified EHR system.										
Task Step 14: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.										
Task Step 15: Assess current baseline of PCP offices and EDs with encounter notification system (ENS) installed.										
Task Step 16: Design and refine target state for installation and use of ENS.										
Task Step 17: Develop plan for installation of ENS in PCP offices and EDs, as laid out in target state.										
Task Step 18: Validate with PPS governance bodies and relevant stakeholders, as needed.										
Task Step 19: Launch and roll out plan for installation of ENS in PCP offices and EDs.										
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										

New York City Health and Hospitals Corporation (PPS ID:52)

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
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 Step 1: Convene Clinical Leadership Team to define PPS-wide protocols for connecting patients to non-emergency PCP and needed community support resources. Synthesize guidelines.										
Task Step 2: Obtain input from PAC on protocols for connecting patients to non-emergency PCP & community support resources. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on protocols for connecting patients to non-emergency PCP & community support resources.										
Task Step 4: Through Hub-based planning process, refine protocols for connecting patients to non-emergency PCP & community support.										
Task Step 5: Define PPS training needs on protocols for connecting patients to non-emergency PCP & community support.										
Task Step 6: Develop curriculum for training on connecting patients to non-emergency PCP & community support; identify training resources and create training plan.										
Task Step 7: Launch and roll out training program.										
Task Step 8: Monitor roll out of protocols and refine as needed.										
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										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	0	0	0	0	0	0	0	0	0	0
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 3: Launch and roll out training program on interim tracking process.										
Task Step 4: Monitor implementation of interim tracking process and refine as needed.										
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										
Task Step 8: Create CCMS Documentation: develop user manual										

New York City Health and Hospitals Corporation (PPS ID:52)

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
specifications, develop user manual(s), review all user documentation, and incorporate user documentation feedback.										
Task Step 9: Develop CCMS training requirements.										
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Establish ED care triage program for at-risk populations										
Task Stand up program based on project requirements										
Task Step 1: Convene Clinical Leadership Team to define initial PPS-wide guidelines for ED care triage program, including BH/SUD considerations. Synthesize guidelines and protocols. Refine over time.										
Task Step 2: Obtain input from PAC on guidelines for ED care triage program. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on ED care triage guidelines and protocols.										
Task Step 4: Through Hub-based planning process, refine ED care triage program guidelines.										
Task Step 5: Monitor roll-out of guidelines and refine as needed.										
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										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 applicable										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards.	214	285	285	285	285	285	285	285	285	285
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	214	285	285	285	285	285	285	285	285	285
Task Encounter Notification Service (ENS) is installed in all PCP offices and EDs	9	12	12	12	12	12	12	12	12	12
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on true and usable primary care capacity and access across the PPS service area. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess existing primary care capacity and access. Segment providers.										
Task Step 3: Identify roles, responsibilities, and processes for effective partnerships between EDs and primary care providers.										
Task Step 4: Contract with partners who intend to participate in this project, including, if applicable, community based behavioral health organizations.										
Task Step 5: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 6: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.										
Task Step 7: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 8: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										
Task Step 9: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.										
Task Step 10: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.										
Task Step 11: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.										
Task Step 12: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.										
Task Step 13: Develop target completion dates for each provider to obtain a certified EHR system.										
Task Step 14: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners.										
Task Step 15: Assess current baseline of PCP offices and EDs with encounter notification system (ENS) installed.										
Task Step 16: Design and refine target state for installation and use of ENS.										
Task Step 17: Develop plan for installation of ENS in PCP offices and EDs, as laid out in target state.										
Task Step 18: Validate with PPS governance bodies and relevant stakeholders, as needed.										
Task Step 19: Launch and roll out plan for installation of ENS in PCP										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
offices and EDs.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide protocols for connecting patients to non-emergency PCP and needed community support resources. Synthesize guidelines.										
Task Step 2: Obtain input from PAC on protocols for connecting patients to non-emergency PCP & community support resources. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on protocols for connecting patients to non-emergency PCP & community support resources.										
Task Step 4: Through Hub-based planning process, refine protocols for connecting patients to non-emergency PCP & community support.										
Task Step 5: Define PPS training needs on protocols for connecting patients to non-emergency PCP & community support.										
Task Step 6: Develop curriculum for training on connecting patients to non-emergency PCP & community support; identify training resources and create training plan.										
Task Step 7: Launch and roll out training program.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 8: Monitor roll out of protocols and refine as needed.										
Milestone #4 Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)										
Task PPS has protocols and operations in place to transport non-acute patients to appropriate care site. (Optional).	0	0	0	0	0	0	0	0	0	0
Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 3: Launch and roll out training program on interim tracking process.										
Task Step 4: Monitor implementation of interim tracking process and refine as needed.										
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										
Task Step 7: Develop CCMS specifications and software										

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, and incorporate user documentation feedback.										
Task Step 9: Develop CCMS training requirements.										
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										

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	
Participating EDs will establish partnerships to community primary care providers with an emphasis on those that are PCMHs and have open access scheduling. a. Achieve NCQA 2014 Level 3 Medical Home standards or NYS Advanced Primary Care Model standards by the end of DSRIP Year 3. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	
For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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).	
Established protocols allowing ED and first responders - under supervision of the ED practitioners - to transport patients with non-acute disorders to alternate care sites including the PCMH to receive more appropriate level of care. (This requirement is optional.)	
Use EHRs and other technical platforms to track all patients engaged in the project.	

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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

Instructions :

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

Our proposed approach to the 30-Day Readmissions project is to implement and standardize Project RED (re-engineered discharge) at all 12 hospitals within the PPS. While 11 of 12 hospitals have implemented some components of Project RED, implementation has not been consistent across the hospitals. Project RED consists of 12 interventions and we believe that implementing all 12 components in 12 hospitals presents a risk to success because of the volume of work. To mitigate this risk, we will pursue a staged implementation. Our patient speed and scale estimates reflect this approach.

One of the Project RED components is to make follow-up medical appointments based on the patient's primary and specialty care needs. As with the ED Care Triage project (3.b.iii), we anticipate challenges in identifying the true and usable capacity of partners, particular during evenings and weekends. Second, we are concerned that patients may not show up for appointments. Patients failing to keep appointments both reduces capacity and also means the patient may not get the care they need. Finally, the process of making appointments may take significant staff time. To address these risks, we intend to develop an approach to determining capacity both within HHC facilities as well as among other partners. This approach will identify technology and workflow requirements. To address concerns about no shows, we will leverage care managers to follow-up with patients about the need for and value of primary care visits. Care managers, community health workers and other staff can also identify barriers to keeping appointments (e.g., transportation), and identify resources to help patients overcome those barriers. Finally, we will take a data-driven approach to determining the optimal workflow for appointment making during discharge planning and determine where improvements may be needed.

Another risk we anticipate is in meeting the needs of particularly complex patients, such as those who are homeless. To mitigate this risk, we intend to work closely with partners with expertise in addressing psycho-social risk factors to better inform the care team of options for these patients and to address operational and/or staffing issues that impede their access to follow-up care.

Finally, the health IT capabilities required to be successful in this project present a risk. Many aspects of the 30-Day Readmissions proposed interventions rely on enhanced IT systems to support: (1) population health management capabilities; (2) functional capabilities to support operations and measure performance; (3) care coordination and management capabilities; (4) improved connectivity within the PPS and with partners, including assistance with meeting Stage 2 Meaningful Use attestation; and, (5) health information exchange (HIE) with RHIO/SHIN-NY and private HIE. To mitigate this risk we intend to: focus on augmenting existing functionality; prioritize partners that are key to being successful within this project; and, identifying the technology and implementation support services that are critical to success.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Benchmarks	
100% Actively Engaged By	**Expected Patient Engagement**
DY3,Q4	18,757

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
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
nholder9	Baseline or Performance Documentation	52_PMDL2815_1_3_20160125135408_OneCity_Health_Patient_Engagement_Commitments.pdf	Please see page 3 with the patient engagement speed commitments for this project, which begin in DY2 Q1.	01/25/2016 01:54 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide protocols for Care Transitions Intervention Model, including partnerships with home care services and other appropriate community agencies. Synthesize guidelines.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on protocols for Care Transitions Intervention Model. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Coordinate with other PPSs in overlapping service areas to ensure consistency in transition protocols, as appropriate.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Care Models Committee reviews and makes consensus-driven recommendation on protocols for Care Transitions Intervention Model.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Through Hub-based planning process, refine protocols for Care Transitions Intervention Model.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Define PPS training needs on protocols for Care Transitions Intervention Model.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 7: Develop curriculum for training on Care Transitions Intervention Model; identify training resources and create training plan.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Launch and roll out training program.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: In coordination with Medicaid Managed Care Organizations (MCOs) and Health Homes (HH), determine current payment models in place and identify opportunities to expand payments for transition of care services.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: In coordination with MCOs and HHs, develop initial plan to expand payments for transition of care services, identifying priority opportunities, needed infrastructure, reporting requirements and negotiation strategies	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Determine structure of legal entity (or entities) to be created for contracting.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Initiate plan to expand payments for transition of care services, as appropriate.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 5: Convene Clinical Leadership Team to define PPS-wide policies to coordinate care transitions with Health Homes and supportive housing, including roles and responsibilities at each stage of the workflow and linking eligible patients to services.									
Task Step 6: Obtain input from PAC on policies to coordinate care transitions with Health Homes and supportive housing. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Care Models Committee reviews and makes consensus-driven recommendation on policies to coordinate care transitions with Health Homes and supportive housing.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8: Through Hub-based planning process, refine policies to coordinate care transitions with Health Homes and supportive housing.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Monitor roll out of policies and refine as needed.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure required social services participate in the project.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Required network social services, including medically tailored home food services, are provided in care transitions.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on social services, including medically tailored home food services, across the PPS service area. Educate partners on PRAT and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess existing social services. Segment providers.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Identify roles, responsibilities, and processes for effective partnerships between acute care hospitals and social services to support care transitions.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 4: Contract with partners as needed.									
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for early notification of planned discharges.	Provider	Hospital	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide transition of care protocols that include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital. Synthesize protocols.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on protocols for early notification, transition care manager visits to patient in hospital. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on protocols for early notification, transition care manager visits to patient in hospital.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine guidelines protocols for early notification, transition care manager visits to patient in hospital.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs on guidelines for protocols for	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2

New York City Health and Hospitals Corporation (PPS ID:52)

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
early notification, transition care manager visits to patient in hospital.									
Task Step 6: Develop curriculum for training on protocols for early notification, transition care manager visits to patient in hospital; identify training resources and create training plan.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Launch and roll out training program.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans (updated in interoperable EHR or updated in primary care provider record). Synthesize policies and procedures.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine policies and procedures for including care transition plans in the patient	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York City Health and Hospitals Corporation (PPS ID:52)

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
medical record and ensuring PCP access to care transition plans.									
Task Step 5: Define PPS training needs on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Develop curriculum for training on including care transition plans in the patient medical record and ensuring PCP access to care transition plans; identify training resources and create training plan.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Launch and roll out training program.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #6 Ensure that a 30-day transition of care period is established.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide policies and procedures to establish a 30 day transition of care period.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on policies and procedures to establish a 30 day transition of care period. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on policies and procedures to establish a 30 day transition of care period.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine policies and procedures to establish a 30 day transition of care period.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Monitor roll out of policies and procedures and refine as needed.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Use EHRs and other technical platforms to track all patients	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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
engaged in the project.									
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll out training program on interim tracking process.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Monitor implementation of interim tracking process and refine as needed.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
documentation, incorporate user documentation feedback.									
Task Step 9: Develop CCMS training requirements.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide protocols for Care Transitions Intervention Model, including partnerships with home care services and other appropriate community agencies. Synthesize guidelines.										
Task Step 2: Obtain input from PAC on protocols for Care Transitions Intervention Model. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Coordinate with other PPSs in overlapping service areas to ensure consistency in transition protocols, as appropriate.										
Task Step 4: Care Models Committee reviews and makes consensus-driven recommendation on protocols for Care Transitions Intervention Model.										
Task Step 5: Through Hub-based planning process, refine protocols for Care Transitions Intervention Model.										
Task Step 6: Define PPS training needs on protocols for Care Transitions Intervention Model.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 7: Develop curriculum for training on Care Transitions Intervention Model; identify training resources and create training plan.										
Task Step 8: Launch and roll out training program.										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Step 1: In coordination with Medicaid Managed Care Organizations (MCOs) and Health Homes (HH), determine current payment models in place and identify opportunities to expand payments for transition of care services.										
Task Step 2: In coordination with MCOs and HHs, develop initial plan to expand payments for transition of care services, identifying priority opportunities, needed infrastructure, reporting requirements and negotiation strategies										
Task Step 3: Determine structure of legal entity (or entities) to be created for contracting.										
Task Step 4: Initiate plan to expand payments for transition of care services, as appropriate.										
Task Step 5: Convene Clinical Leadership Team to define PPS-wide policies to coordinate care transitions with Health Homes and supportive housing, including roles and responsibilities at each stage of the workflow and linking eligible patients to services.										
Task Step 6: Obtain input from PAC on policies to coordinate care transitions with Health Homes and supportive housing. PAC is										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 7: Care Models Committee reviews and makes consensus-driven recommendation on policies to coordinate care transitions with Health Homes and supportive housing.										
Task Step 8: Through Hub-based planning process, refine policies to coordinate care transitions with Health Homes and supportive housing.										
Task Step 9: Monitor roll out of policies and refine as needed.										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on social services, including medically tailored home food services, across the PPS service area. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess existing social services. Segment providers.										
Task Step 3: Identify roles, responsibilities, and processes for effective partnerships between acute care hospitals and social services to support care transitions.										
Task Step 4: Contract with partners as needed.										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	190	379	758	758	758
Task Policies and procedures are in place for early notification of planned discharges.	0	0	0	0	0	183	366	732	732	732

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 are in place for early notification of planned discharges.	0	0	0	0	0	3	6	12	12	12
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide transition of care protocols that include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital. Synthesize protocols.										
Task Step 2: Obtain input from PAC on protocols for early notification, transition care manager visits to patient in hospital. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on protocols for early notification, transition care manager visits to patient in hospital.										
Task Step 4: Through Hub-based planning process, refine guidelines protocols for early notification, transition care manager visits to patient in hospital.										
Task Step 5: Define PPS training needs on guidelines for protocols for early notification, transition care manager visits to patient in hospital.										
Task Step 6: Develop curriculum for training on protocols for early notification, transition care manager visits to patient in hospital; identify training resources and create training plan.										
Task Step 7: Launch and roll out training program.										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										
Task Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Convene Clinical Leadership Team to define PPS-wide policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans (updated in interoperable EHR or updated in primary care provider record). Synthesize policies and procedures.										
Task Step 2: Obtain input from PAC on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.										
Task Step 4: Through Hub-based planning process, refine policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.										
Task Step 5: Define PPS training needs on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.										
Task Step 6: Develop curriculum for training on including care transition plans in the patient medical record and ensuring PCP access to care transition plans; identify training resources and create training plan.										
Task Step 7: Launch and roll out training program.										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide policies and procedures to establish a 30 day transition of care period.										
Task Step 2: Obtain input from PAC on policies and procedures to										

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
establish a 30 day transition of care period. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on policies and procedures to establish a 30 day transition of care period.										
Task Step 4: Through Hub-based planning process, refine policies and procedures to establish a 30 day transition of care period.										
Task Step 5: Monitor roll out of policies and procedures and refine as needed.										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 3: Launch and roll out training program on interim tracking process.										
Task Step 4: Monitor implementation of interim tracking process and refine as needed.										
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.										
Task Step 9: Develop CCMS training requirements.										
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.										
Task Standardized protocols are in place to manage overall population health and perform as an integrated clinical team are in place.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide protocols for Care Transitions Intervention Model, including partnerships with home care services and other appropriate community agencies. Synthesize guidelines.										
Task Step 2: Obtain input from PAC on protocols for Care Transitions Intervention Model. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Coordinate with other PPSs in overlapping service areas to ensure consistency in transition protocols, as appropriate.										
Task Step 4: Care Models Committee reviews and makes consensus-driven recommendation on protocols for Care Transitions Intervention Model.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Through Hub-based planning process, refine protocols for Care Transitions Intervention Model.										
Task Step 6: Define PPS training needs on protocols for Care Transitions Intervention Model.										
Task Step 7: Develop curriculum for training on Care Transitions Intervention Model; identify training resources and create training plan.										
Task Step 8: Launch and roll out training program.										
Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.										
Task A payment strategy for the transition of care services is developed in concert with Medicaid Managed Care Plans and Health Homes.										
Task Coordination of care strategies focused on care transition are in place, in concert with Medicaid Managed Care groups and Health Homes.										
Task PPS has protocol and process in place to identify Health-Home eligible patients and link them to services as required under ACA.										
Task Step 1: In coordination with Medicaid Managed Care Organizations (MCOs) and Health Homes (HH), determine current payment models in place and identify opportunities to expand payments for transition of care services.										
Task Step 2: In coordination with MCOs and HHs, develop initial plan to expand payments for transition of care services, identifying priority opportunities, needed infrastructure, reporting requirements and negotiation strategies										
Task Step 3: Determine structure of legal entity (or entities) to be created for contracting.										
Task Step 4: Initiate plan to expand payments for transition of care services, as appropriate.										
Task Step 5: Convene Clinical Leadership Team to define PPS-wide										

New York City Health and Hospitals Corporation (PPS ID:52)

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
policies to coordinate care transitions with Health Homes and supportive housing, including roles and responsibilities at each stage of the workflow and linking eligible patients to services.										
Task Step 6: Obtain input from PAC on policies to coordinate care transitions with Health Homes and supportive housing. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 7: Care Models Committee reviews and makes consensus-driven recommendation on policies to coordinate care transitions with Health Homes and supportive housing.										
Task Step 8: Through Hub-based planning process, refine policies to coordinate care transitions with Health Homes and supportive housing.										
Task Step 9: Monitor roll out of policies and refine as needed.										
Milestone #3 Ensure required social services participate in the project.										
Task Required network social services, including medically tailored home food services, are provided in care transitions.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to gather information on social services, including medically tailored home food services, across the PPS service area. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess existing social services. Segment providers.										
Task Step 3: Identify roles, responsibilities, and processes for effective partnerships between acute care hospitals and social services to support care transitions.										
Task Step 4: Contract with partners as needed.										
Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Policies and procedures are in place for early notification of planned discharges.	758	758	758	758	758	758	758	758	758	758
Task Policies and procedures are in place for early notification of planned discharges.	732	732	732	732	732	732	732	732	732	732
Task Policies and procedures are in place for early notification of planned discharges.	12	12	12	12	12	12	12	12	12	12
Task PPS has program in place that allows care managers access to visit patients in the hospital and provide care transition services and advisement.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide transition of care protocols that include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital. Synthesize protocols.										
Task Step 2: Obtain input from PAC on protocols for early notification, transition care manager visits to patient in hospital. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on protocols for early notification, transition care manager visits to patient in hospital.										
Task Step 4: Through Hub-based planning process, refine guidelines protocols for early notification, transition care manager visits to patient in hospital.										
Task Step 5: Define PPS training needs on guidelines for protocols for early notification, transition care manager visits to patient in hospital.										
Task Step 6: Develop curriculum for training on protocols for early notification, transition care manager visits to patient in hospital; identify training resources and create training plan.										
Task Step 7: Launch and roll out training program.										
Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Policies and procedures are in place for including care transition plans in patient medical record and ensuring medical record is updated in interoperable EHR or updated in primary care provider record.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans (updated in interoperable EHR or updated in primary care provider record). Synthesize policies and procedures.										
Task Step 2: Obtain input from PAC on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.										
Task Step 4: Through Hub-based planning process, refine policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.										
Task Step 5: Define PPS training needs on policies and procedures for including care transition plans in the patient medical record and ensuring PCP access to care transition plans.										
Task Step 6: Develop curriculum for training on including care transition plans in the patient medical record and ensuring PCP access to care transition plans; identify training resources and create training plan.										
Task Step 7: Launch and roll out training program.										
Milestone #6 Ensure that a 30-day transition of care period is established.										
Task Policies and procedures reflect the requirement that 30 day transition of care period is implemented and utilized.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Convene Clinical Leadership Team to define PPS-wide policies and procedures to establish a 30 day transition of care period.										
Task Step 2: Obtain input from PAC on policies and procedures to establish a 30 day transition of care period. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on policies and procedures to establish a 30 day transition of care period.										
Task Step 4: Through Hub-based planning process, refine policies and procedures to establish a 30 day transition of care period.										
Task Step 5: Monitor roll out of policies and procedures and refine as needed.										
Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 3: Launch and roll out training program on interim tracking process.										
Task Step 4: Monitor implementation of interim tracking process and refine as needed.										
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.										
Task Step 9: Develop CCMS training requirements.										
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										

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 standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	
Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	
Ensure required social services participate in the project.	
Transition of care protocols will include early notification of planned	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	
Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	
Ensure that a 30-day transition of care period is established.	
Use EHRs and other technical platforms to track all patients engaged in the project.	

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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

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PPS Defined Milestones Narrative Text

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

We have identified a number of risks associated with this project. First, we must find, identify and connect with the uninsured population, including the undocumented and those without formal connection to the healthcare system. Identifying and connecting with this population will prove challenging. To mitigate this risk, we will contract and/or partner with organizations that have culturally-responsive approaches and engage trusted community leaders. We will also coordinate with CBOs that have existing relationships to the community and outreach expertise.

Our ability to be successful in overcoming cultural barriers for new immigrants -- some of whom have not had contact with a formal healthcare system -- also presents a risk. We intend to mitigate this risk by partnering with CBOs that have established relationships within these communities, and further developing our own relationships with these populations. The use of community health workers and peer educators will also support outreach and engagement efforts.

Finally, uncertainty related to workflows and dataflows presents a risk. Seamless data flow will require the deployment of mobile technology to field staff conducting assessments in the community. Challenges to deployment of these types of technologies will require additional mitigation strategies, including the use of paper tools.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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**
DY2,Q4	55,000

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
0	0	0.00%	11,000	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (11,000)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
nholder9	Baseline or Performance Documentation	52_PMDL3615_1_3_20160125135932_OneCity_Health_Patient_Engagement_Commitments.pdf	Please see page 4 with the patient engagement speed commitments for this project, which begin in DY1 Q4.	01/25/2016 02:00 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
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	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Educate partners and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Analyze current state baseline to assess existing CBO and patient activation resources.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Identify patient activation roles, responsibilities, and processes for patient activation.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Contract with CBOs.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Patient Activation Measure(R) (PAM(R)) training team established.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 1: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.									
Task Step 2: Develop curriculum and training for PAM administration and coaching/activation to augment the training offered under the Insignia contract.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll-out training program for core teams of PAM administrators and PAM coaching/activation experts, with realization these groups may in some cases differ in composition.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Analyze Community Needs Assessments to identify "hot spot" areas for UI, NU, and LU populations.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Conduct additional analysis and validation of CNA-identified "hot spot" areas by examining other available data source (e.g., census data, community surveys and reports).	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Generate outreach lists for "hot spot" areas based on attributed patients and additional information. Coordinate with collaborating PPSs, as appropriate.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Contract with CBOs to conduct outreach to identified UI, NU, and LU populations.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Survey the targeted population about healthcare needs in the PPS' region.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Community engagement forums and other information-gathering mechanisms established and performed.									
Task Step 1: Analyze Partner Readiness Assessment Tool (PRAT), Community Needs Assessments, and other community reports/surveys/data to understand baseline healthcare needs in the PPS region. PRAT includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Engage community members through the PAC, Stakeholder Engagement Sub-Committee, Hub Steering Committees, and other forums on community needs. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: As needed, conduct additional surveys to better understand community healthcare needs.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task PPS Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop curriculum and training for providers in "hot spot" areas on PAM administration and coaching/activation techniques such as shared decision-making, measurements of health literacy, and cultural competency to augment the training offered under the Insignia contract.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll-out training program for providers.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 #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	07/01/2015	03/31/2017	07/01/2015	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Work with MCOs to obtain lists of PCPs assigned to NU and LU enrollees.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Establish procedures and protocols that allow the PPS to work with MCOs to reconnect beneficiaries to his/her designated PCP.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Work with MCOs to establish information-exchange agreements, including sharing utilization reports.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	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	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task For each PAM(R) activation level, baseline and set intervals	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2

New York City Health and Hospitals Corporation (PPS ID:52)

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
toward improvement determined at the beginning of each performance period (defined by the state).									
Task Step 1: Perform baseline analysis for each beneficiary cohort, per methodology determined by the state.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: At pre-determined intervals, conduct analyses to determine change against the baseline.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #8 Include beneficiaries in development team to promote preventive care.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Through PAC and, to the extent possible, through operational governance committees, ensure patient input in the design of preventive care promotion activities. Refine as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	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. • 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	Project	N/A	In Progress	07/01/2015	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
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	09/30/2017	07/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Establish workflows determining how PPS partners will assess beneficiaries for PAM screening eligibility, PCP linkage, or healthcare benefit education.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Determine which partners will conduct PAM screenings, which will link beneficiaries to PCPs, and which will deliver healthcare benefit education.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 3: Conduct PAMs, linkages, and healthcare benefit education to eligible beneficiaries. Measure changes in PAM scores for this cohort each year.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 4: Work with MCOs to obtain lists of PCPs assigned to NU and LU enrollees.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 5: Establish procedures and protocols that allow the PPS to work with MCOs to reconnect beneficiaries to his/her designated PCP.									
Task Step 6: Work with MCOs to establish information-exchange agreements, including sharing utilization reports.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Provide member engagement lists to relevant insurance companies at required intervals.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #10 Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Volume of non-emergent visits for UI, NU, and LU populations increased.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Determine baseline non-emergent care volume for UI, NU, and LU patients.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Through connecting NU and LU patients to the MCO-designated PCP, and through healthcare benefits education, seek to increase the volume of non-emergent care provided.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 3: For UI persons eligible for insurance, augment current processes as appropriate across all partner types to enroll patients in coverage.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 4: For UI persons ineligible for insurance, augment processes as appropriate across partner types to educate and provide information on HHC Options or similar services to improve access and linkage to non-emergent, longitudinal services.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	Project	N/A	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Community navigators identified and contracted.	Provider	PAM(R) Providers	In Progress	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 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	04/01/2015	09/30/2017	04/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Educate partners and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Analyze current state baseline to assess existing CBO and community navigator resources.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Identify CBO and partner roles, responsibilities, and processes for connecting patients to healthcare coverage and educating patients about community healthcare resources.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Develop culturally and linguistically appropriate curriculum and training for those connecting patients to healthcare coverage and educating patients about community healthcare resources.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 6: Identify training resources and create training plan.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Launch and roll-out training program. Refine as needed.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 8: Contract with CBOs and other partners.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #12 Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures for customer service complaints and appeals developed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Review existing HHC processes and resources deployed to handle complaints and provide customer service.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Adapt existing HHC policies, procedures, and processes	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
for receiving and responding to beneficiary complaints and for providing customer service to specific needs of Project 11 program.									
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	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task List of community navigators formally trained in the PAM(R).	Provider	PAM(R) Providers	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Identify roles, responsibilities, and processes for community navigator patient activation and education training.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Develop curriculum and training for community navigators on PAM administration and patient activation and education techniques to augment the training offered under the Insignia contract.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Launch and roll-out training program for community navigators.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	Provider	PAM(R) Providers	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Identify roles, responsibilities, and processes for patient education training by community navigators.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 2: Develop curriculum and training for community navigators.									
Task Step 3: Identify training resources and create training plan.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Launch and roll-out training program. Refine as needed.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 5: Track navigator placements across PPS.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #15 Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Navigators educated about insurance options and healthcare resources available to populations in this project.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Step 1: Identify roles, responsibilities, and processes for patient education training regarding insurance options and healthcare resources by community navigators.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Refine approach to defining current-state patient education regarding insurance options and healthcare resources. Establish cross-partner workgroup(s) to identify potential training team candidates and develop overall timeline for training in patient education on insurance options and healthcare resources.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Develop curriculum and training for community navigators on patient education on insurance options and healthcare resources.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Launch and roll-out training program for community navigators.	Project		In Progress	01/01/2016	09/30/2017	01/01/2016	09/30/2017	09/30/2017	DY3 Q2
Milestone #16 Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	Project	N/A	In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2
Task Timely access for navigator when connecting members to services.	Project		In Progress	10/01/2015	09/30/2017	10/01/2015	09/30/2017	09/30/2017	DY3 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Establish policies, procedures, and processes for receiving and responding to community navigator requests.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Devlop training curriculum for provider intake staff on receiving navigator calls and requests to establish primary and preventive services for community members.	Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Launch and roll-out training program for intake staff.	Project		In Progress	03/31/2017	09/30/2017	03/31/2017	09/30/2017	09/30/2017	DY3 Q2
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	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 Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "end state."	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Launch and roll out training program on interim tracking process..	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Monitor implementation of interim tracking process and	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
refine as needed.									
Task Step 7: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 8: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 11: Develop CCMS training requirements.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 12: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 13: Produce report summarizing availability of registry functionality across PPS.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Milestone #1 Contract or partner with community-based organizations (CBOs)										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
to 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 Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Educate partners and roll out PRAT.										
Task Step 3: Analyze current state baseline to assess existing CBO and patient activation resources.										
Task Step 4: Identify patient activation roles, responsibilities, and processes for patient activation.										
Task Step 5: Contract with CBOs.										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task Step 1: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.										
Task Step 2: Develop curriculum and training for PAM administration and coaching/activation to augment the training offered under the Insignia contract.										
Task Step 3: Launch and roll-out training program for core teams of PAM administrators and PAM coaching/activation experts, with realization these groups may in some cases differ in composition.										
Milestone #3 Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach										

New York City Health and Hospitals Corporation (PPS ID:52)

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
within the identified "hot spot" areas.										
Task Analysis to identify "hot spot" areas completed and CBOs performing outreach engaged.										
Task Step 1: Analyze Community Needs Assessments to identify "hot spot" areas for UI, NU, and LU populations.										
Task Step 2: Conduct additional analysis and validation of CNA-identified "hot spot" areas by examining other available data source (e.g., census data, community surveys and reports).										
Task Step 3: Generate outreach lists for "hot spot" areas based on attributed patients and additional information. Coordinate with collaborating PPSs, as appropriate.										
Task Step 4: Contract with CBOs to conduct outreach to identified UI, NU, and LU populations.										
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 Step 1: Analyze Partner Readiness Assessment Tool (PRAT), Community Needs Assessments, and other community reports/surveys/data to understand baseline healthcare needs in the PPS region. PRAT includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Engage community members through the PAC, Stakeholder Engagement Sub-Committee, Hub Steering Committees, and other forums on community needs. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: As needed, conduct additional surveys to better understand community healthcare needs.										
Milestone #5 Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Providers (located in "hot spot" areas) trained in patient activation techniques by "PAM(R) trainers".										
Task Step 1: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.										
Task Step 2: Develop curriculum and training for providers in "hot spot" areas on PAM administration and coaching/activation techniques such as shared decision-making, measurements of health literacy, and cultural competency to augment the training offered under the Insignia contract.										
Task Step 3: Launch and roll-out training program for providers.										
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 Step 1: Work with MCOs to obtain lists of PCPs assigned to NU and LU enrollees.										
Task Step 2: Establish procedures and protocols that allow the PPS to work with MCOs to reconnect beneficiaries to his/her designated PCP.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 3: Work with MCOs to establish information-exchange agreements, including sharing utilization reports.										
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 Step 1: Perform baseline analysis for each beneficiary cohort, per methodology determined by the state.										
Task Step 2: At pre-determined intervals, conduct analyses to determine change against the baseline.										
Milestone #8 Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task Step 1: Through PAC and, to the extent possible, through operational governance committees, ensure patient input in the design of preventive care promotion activities. Refine as needed.										
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										

New York City Health and Hospitals Corporation (PPS ID:52)

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
is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task Step 1: Establish workflows determining how PPS partners will assess beneficiaries for PAM screening eligibility, PCP linkage, or healthcare benefit education.										
Task Step 2: Determine which partners will conduct PAM screenings, which will link beneficiaries to PCPs, and which will deliver healthcare benefit education.										
Task Step 3: Conduct PAMs, linkages, and healthcare benefit education to eligible beneficiaries. Measure changes in PAM scores for this cohort each year.										
Task Step 4: Work with MCOs to obtain lists of PCPs assigned to NU and LU enrollees.										
Task Step 5: Establish procedures and protocols that allow the PPS to work with MCOs to reconnect beneficiaries to his/her designated										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.										
Task Step 6: Work with MCOs to establish information-exchange agreements, including sharing utilization reports.										
Task Step 7: Provide member engagement lists to relevant insurance companies at required intervals.										
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 Step 1: Determine baseline non-emergent care volume for UI, NU, and LU patients.										
Task Step 2: Through connecting NU and LU patients to the MCO-designated PCP, and through healthcare benefits education, seek to increase the volume of non-emergent care provided.										
Task Step 3: For UI persons eligible for insurance, augment current processes as appropriate across all partner types to enroll patients in coverage.										
Task Step 4: For UI persons ineligible for insurance, augment processes as appropriate across partner types to educate and provide information on HHC Options or similar services to improve access and linkage to non-emergent, longitudinal services.										
Milestone #11 Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.										
Task Community navigators identified and contracted.	0	0	0	0	0	75	188	375	563	750
Task Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	0	0	0	0	0	75	188	375	563	750
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT,										

New York City Health and Hospitals Corporation (PPS ID:52)

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
operational, and staffing capacity and capabilities.										
Task Step 2: Educate partners and roll out PRAT.										
Task Step 3: Analyze current state baseline to assess existing CBO and community navigator resources.										
Task Step 4: Identify CBO and partner roles, responsibilities, and processes for connecting patients to healthcare coverage and educating patients about community healthcare resources.										
Task Step 5: Develop culturally and linguistically appropriate curriculum and training for those connecting patients to healthcare coverage and educating patients about community healthcare resources.										
Task Step 6: Identify training resources and create training plan.										
Task Step 7: Launch and roll-out training program. Refine as needed.										
Task Step 8: Contract with CBOs and other partners.										
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 Step 1: Review existing HHC processes and resources deployed to handle complaints and provide customer service.										
Task Step 2: Adapt existing HHC policies, procedures, and processes for receiving and responding to beneficiary complaints and for providing customer service to specific needs of Project 11 program.										
Milestone #13 Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	0	0	0	0	0	188	375	750	750	750
Task Step 1: Identify roles, responsibilities, and processes for community navigator patient activation and education training.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.										
Task Step 3: Develop curriculum and training for community navigators on PAM administration and patient activation and education techniques to augment the training offered under the Insignia contract.										
Task Step 4: Launch and roll-out training program for community navigators.										
Milestone #14 Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.										
Task Community navigators prominently placed (with high visibility) at appropriate locations within identified "hot spot" areas.	0	0	0	0	0	75	188	375	563	750
Task Step 1: Identify roles, responsibilities, and processes for patient education training by community navigators.										
Task Step 2: Develop curriculum and training for community navigators.										
Task Step 3: Identify training resources and create training plan.										
Task Step 4: Launch and roll-out training program. Refine as needed.										
Task Step 5: Track navigator placements across PPS.										
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 Step 1: Identify roles, responsibilities, and processes for patient education training regarding insurance options and healthcare resources by community navigators.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Refine approach to defining current-state patient education regarding insurance options and healthcare resources. Establish cross-partner workgroup(s) to identify potential training team candidates and develop overall timeline for training in patient education on insurance options and healthcare resources.										
Task Step 3: Develop curriculum and training for community navigators on patient education on insurance options and healthcare resources.										
Task Step 4: Launch and roll-out training program for community navigators.										
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 Step 1: Establish policies, procedures, and processes for receiving and responding to community navigator requests.										
Task Step 2: Devlop training curriculum for provider intake staff on receiving navigator calls and requests to establish primary and preventive services for community members.										
Task Step 3: Launch and roll-out training program for intake staff.										
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 Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.										
Task Step 2: Determine IT infrastructure needed to support population										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 management vision and how various IT systems should relate to each other in the "end state."										
Task Step 3: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 4: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 5: Launch and roll out training program on interim tracking process..										
Task Step 6: Monitor implementation of interim tracking process and refine as needed.										
Task Step 7: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										
Task Step 8: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										
Task Step 9: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										
Task Step 10: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.										
Task Step 11: Develop CCMS training requirements.										
Task Step 12: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 13: Produce report summarizing availability of registry functionality across PPS.										

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 Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Educate partners and roll out PRAT.										
Task Step 3: Analyze current state baseline to assess existing CBO and patient activation resources.										
Task Step 4: Identify patient activation roles, responsibilities, and processes for patient activation.										
Task Step 5: Contract with CBOs.										
Milestone #2 Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.										
Task Patient Activation Measure(R) (PAM(R)) training team established.										
Task Step 1: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.										
Task Step 2: Develop curriculum and training for PAM administration										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 coaching/activation to augment the training offered under the Insignia contract.										
Task Step 3: Launch and roll-out training program for core teams of PAM administrators and PAM coaching/activation experts, with realization these groups may in some cases differ in composition.										
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 Step 1: Analyze Community Needs Assessments to identify "hot spot" areas for UI, NU, and LU populations.										
Task Step 2: Conduct additional analysis and validation of CNA-identified "hot spot" areas by examining other available data source (e.g., census data, community surveys and reports).										
Task Step 3: Generate outreach lists for "hot spot" areas based on attributed patients and additional information. Coordinate with collaborating PPSs, as appropriate.										
Task Step 4: Contract with CBOs to conduct outreach to identified UI, NU, and LU populations.										
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 Step 1: Analyze Partner Readiness Assessment Tool (PRAT), Community Needs Assessments, and other community reports/surveys/data to understand baseline healthcare needs in the PPS region. PRAT includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Engage community members through the PAC, Stakeholder Engagement Sub-Committee, Hub Steering Committees, and other forums on community needs. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 3: As needed, conduct additional surveys to better understand community healthcare needs.										
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 Step 1: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.										
Task Step 2: Develop curriculum and training for providers in "hot spot" areas on PAM administration and coaching/activation techniques such as shared decision-making, measurements of health literacy, and cultural competency to augment the training offered under the Insignia contract.										
Task Step 3: Launch and roll-out training program for providers.										
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.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Work with MCOs to obtain lists of PCPs assigned to NU and LU enrollees.										
Task Step 2: Establish procedures and protocols that allow the PPS to work with MCOs to reconnect beneficiaries to his/her designated PCP.										
Task Step 3: Work with MCOs to establish information-exchange agreements, including sharing utilization reports.										
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 Step 1: Perform baseline analysis for each beneficiary cohort, per methodology determined by the state.										
Task Step 2: At pre-determined intervals, conduct analyses to determine change against the baseline.										
Milestone #8 Include beneficiaries in development team to promote preventive care.										
Task Beneficiaries are utilized as a resource in program development and awareness efforts of preventive care services.										
Task Step 1: Through PAC and, to the extent possible, through operational governance committees, ensure patient input in the design of preventive care promotion activities. Refine as needed.										
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.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
• Individual member's score must be averaged to calculate a baseline measure for that year's cohort. • The cohort must be followed for the entirety of the DSRIP program. • On an annual basis, assess individual members' and each cohort's level of engagement, with the goal of moving beneficiaries to a higher level of activation. • If the beneficiary is deemed to be LU & NU but has a designated PCP who is not part of the PPS' network, counsel the beneficiary on better utilizing his/her existing healthcare benefits, while also encouraging the beneficiary to reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.										
Task Performance measurement reports established, including but not limited to: - Number of patients screened, by engagement level - Number of clinicians trained in PAM(R) survey implementation - Number of patient: PCP bridges established - Number of patients identified, linked by MCOs to which they are associated - Member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis - Member engagement lists to DOH (for NU & LU populations) on a monthly basis - Annual report assessing individual member and the overall cohort's level of engagement										
Task Step 1: Establish workflows determining how PPS partners will assess beneficiaries for PAM screening eligibility, PCP linkage, or healthcare benefit education.										
Task Step 2: Determine which partners will conduct PAM screenings, which will link beneficiaries to PCPs, and which will deliver healthcare benefit education.										
Task Step 3: Conduct PAMs, linkages, and healthcare benefit education to eligible beneficiaries. Measure changes in PAM										

New York City Health and Hospitals Corporation (PPS ID:52)

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
scores for this cohort each year.										
Task Step 4: Work with MCOs to obtain lists of PCPs assigned to NU and LU enrollees.										
Task Step 5: Establish procedures and protocols that allow the PPS to work with MCOs to reconnect beneficiaries to his/her designated PCP.										
Task Step 6: Work with MCOs to establish information-exchange agreements, including sharing utilization reports.										
Task Step 7: Provide member engagement lists to relevant insurance companies at required intervals.										
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 Step 1: Determine baseline non-emergent care volume for UI, NU, and LU patients.										
Task Step 2: Through connecting NU and LU patients to the MCO-designated PCP, and through healthcare benefits education, seek to increase the volume of non-emergent care provided.										
Task Step 3: For UI persons eligible for insurance, augment current processes as appropriate across all partner types to enroll patients in coverage.										
Task Step 4: For UI persons ineligible for insurance, augment processes as appropriate across partner types to educate and provide information on HHC Options or similar services to improve access and linkage to non-emergent, longitudinal services.										
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.	750	750	750	750	750	750	750	750	750	750

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Community navigators trained in connectivity to healthcare coverage and community healthcare resources, (including primary and preventive services), as well as patient education.	750	750	750	750	750	750	750	750	750	750
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities.										
Task Step 2: Educate partners and roll out PRAT.										
Task Step 3: Analyze current state baseline to assess existing CBO and community navigator resources.										
Task Step 4: Identify CBO and partner roles, responsibilities, and processes for connecting patients to healthcare coverage and educating patients about community healthcare resources.										
Task Step 5: Develop culturally and linguistically appropriate curriculum and training for those connecting patients to healthcare coverage and educating patients about community healthcare resources.										
Task Step 6: Identify training resources and create training plan.										
Task Step 7: Launch and roll-out training program. Refine as needed.										
Task Step 8: Contract with CBOs and other partners.										
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 Step 1: Review existing HHC processes and resources deployed to handle complaints and provide customer service.										
Task Step 2: Adapt existing HHC policies, procedures, and processes for receiving and responding to beneficiary complaints and for providing customer service to specific needs of Project 11 program.										
Milestone #13 Train community navigators in patient activation and education,										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 how to appropriately assist project beneficiaries using the PAM(R).										
Task List of community navigators formally trained in the PAM(R).	750	750	750	750	750	750	750	750	750	750
Task Step 1: Identify roles, responsibilities, and processes for community navigator patient activation and education training.										
Task Step 2: Refine approach to defining current-state coaching and patient activation activities across the PPS. Establish cross-partner workgroup(s) to identify potential PAM training team candidates and develop overall timeline for training in PAM administration and patient coaching/activation.										
Task Step 3: Develop curriculum and training for community navigators on PAM administration and patient activation and education techniques to augment the training offered under the Insignia contract.										
Task Step 4: Launch and roll-out training program for community navigators.										
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.	750	750	750	750	750	750	750	750	750	750
Task Step 1: Identify roles, responsibilities, and processes for patient education training by community navigators.										
Task Step 2: Develop curriculum and training for community navigators.										
Task Step 3: Identify training resources and create training plan.										
Task Step 4: Launch and roll-out training program. Refine as needed.										
Task Step 5: Track navigator placements across PPS.										
Milestone #15 Inform and educate navigators about insurance options and										

New York City Health and Hospitals Corporation (PPS ID:52)

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
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 Step 1: Identify roles, responsibilities, and processes for patient education training regarding insurance options and healthcare resources by community navigators.										
Task Step 2: Refine approach to defining current-state patient education regarding insurance options and healthcare resources. Establish cross-partner workgroup(s) to identify potential training team candidates and develop overall timeline for training in patient education on insurance options and healthcare resources.										
Task Step 3: Develop curriculum and training for community navigators on patient education on insurance options and healthcare resources.										
Task Step 4: Launch and roll-out training program for community navigators.										
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 Step 1: Establish policies, procedures, and processes for receiving and responding to community navigator requests.										
Task Step 2: Devlop training curriculum for provider intake staff on receiving navigator calls and requests to establish primary and preventive services for community members.										
Task Step 3: Launch and roll-out training program for intake staff.										
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										

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
able to track actively engaged patients for project milestone reporting.										
Task Step 1: Develop current-state assessment of PPS population health management capabilities through a Partner Readiness Assessment Tool and in-depth interviews with representative care management providers and primary care practices.										
Task Step 2: Determine IT infrastructure needed to support population health management vision and how various IT systems should relate to each other in the "end state."										
Task Step 3: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 4: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 5: Launch and roll out training program on interim tracking process..										
Task Step 6: Monitor implementation of interim tracking process and refine as needed.										
Task Step 7: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										
Task Step 8: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										
Task Step 9: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										
Task Step 10: Create CCMS Documentation: develop user manual										

New York City Health and Hospitals Corporation (PPS ID:52)

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
specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.										
Task Step 11: Develop CCMS training requirements.										
Task Step 12: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										
Task Step 13: Produce report summarizing availability of registry functionality across PPS.										

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.	
Establish a PPS-wide training team, comprised of members with training in PAM(R) and expertise in patient activation and engagement.	
Identify UI, NU, and LU "hot spot" areas (e.g., emergency rooms). Contract or partner with CBOs to perform outreach within the identified "hot spot" areas.	
Survey the targeted population about healthcare needs in the PPS' region.	
Train providers located within "hot spots" on patient activation techniques, such as shared decision-making, measurements of health literacy, and cultural competency.	
Obtain list of PCPs assigned to NU and LU enrollees from MCOs. Along with the member's MCO and assigned PCP, reconnect beneficiaries to his/her designated PCP (see outcome	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
measurements in #10). • This patient activation project should not be used as a mechanism to inappropriately move members to different health plans and PCPs, but rather, shall focus on establishing connectivity to resources already available to the member. • Work with respective MCOs and PCPs to ensure proactive outreach to beneficiaries. Sufficient information must be provided regarding insurance coverage, language resources, and availability of primary and preventive care services. The state must review and approve any educational materials, which must comply with state marketing guidelines and federal regulations as outlined in 42 CFR §438.104.	
Baseline each beneficiary cohort (per method developed by state) to appropriately identify cohorts using PAM(R) during the first year of the project and again, at set intervals. Baselines, as well as intervals towards improvement, must be set for each cohort at the beginning of each performance period.	
Include beneficiaries in development team to promote preventive care.	
Measure PAM(R) components, including: • Screen patient status (UI, NU and LU) and collect 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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
reconnect with his/her designated PCP. • The PPS will NOT be responsible for assessing the patient via PAM(R) survey. • PPS will be responsible for providing the most current contact information to the beneficiary's MCO for outreach purposes. • Provide member engagement lists to relevant insurance companies (for NU & LU populations) on a monthly basis, as well as to DOH on a quarterly basis.	
Increase the volume of non-emergent (primary, behavioral, dental) care provided to UI, NU, and LU persons.	
Contract or partner with CBOs to develop a group of community navigators who are trained in connectivity to healthcare coverage, community healthcare resources (including for primary and preventive services) and patient education.	
Develop a process for Medicaid recipients and project participants to report complaints and receive customer service.	
Train community navigators in patient activation and education, including how to appropriately assist project beneficiaries using the PAM(R).	
Ensure direct hand-offs to navigators who are prominently placed at "hot spots," partnered CBOs, emergency departments, or community events, so as to facilitate education regarding health insurance coverage, age-appropriate primary and preventive healthcare services and resources.	
Inform and educate navigators about insurance options and healthcare resources available to UI, NU, and LU populations.	
Ensure appropriate and timely access for navigators when attempting to establish primary and preventive services for a community member.	
Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, to track all patients engaged in the project.	In regards to step 7 of this milestone, in accordance with State guidance, Insignia"s Flourish system is being used to track engaged patients instead of a separate contracted vendor.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone Review Status

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

We anticipate execution risk related to resource- and infrastructure-related capacity, the significant variation in co-location models currently deployed across PPS partners, and the ability to integrate this effort with existing initiatives introduced by the partner organization or other NYS or Federal mandates. With regard to capacity, we have seen from CNA and assessment of partner staffing and physical infrastructure that at baseline we currently have inadequate capacity to meaningfully improve outcomes. We intend to mitigate this risk through several approaches: 1) for appropriate resourcing, we will optimize staffing, engage in cross-training among practice teams, optimize practice hours of operation, and optimize coordination of capacity across the PPS according to feasibility of patient access. We will also work to ensure appropriate use of psychiatrists so that psychiatrists treat the most serious BH disorders and stable patients are transferred to PCPs with psychiatric consultation available as needed. 2) For physical infrastructure, the PPS will await state capital funding award announcements with realization that underfunding will impede ability to complete planned space conversion. 3) To mitigate the capital funding risk, our implementation approach allows sites to use the IMPACT model where co-location is not feasible.

We expect that the practice sites across our PPS employ highly variable models, all under the term "co-location." The execution risk associated with this variability is the perhaps significant effort to redesign current offerings in order to employ a uniform model with well-defined requirements and common definitions of integration and co-location. We will determine the existing availability of integrated care using these definitions. Based on these data, we may adjust our implementation approach.

Another risk to implementation is the integration of this effort with the ongoing efforts to prepare for HARP implementation across a number of PPS sites representing significant patient volume. To mitigate this risk, over the last several months we have coordinated planning through weekly meetings and joint pilot site selection such that transformation efforts are maximally aligned. For maximum performance, we will continue these alignment efforts so that behavioral health frontline teams and management have the simplest possible integrated roadmap for transformation.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	106,477

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
0	0	0.00%	10,648	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (10,648)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
nholder9	Baseline or Performance Documentation	52_PMDL3715_1_3_20160125142133_OneCity_Health_Patient_Engagement_Commitments.pdf	Please see page 5 with the patient engagement speed commitments for this project, which begin in DY1 Q4.	01/25/2016 02:22 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Behavioral health services are co-located within PCMH/APC practices and are available.		Provider	Mental Health	In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Define process by which to prioritize primary care sites for co-located behavioral health services (e.g., based on patient need, site readiness including readiness for 2014 NCQA Level 3 PCMH / Advanced Primary Care Model standards, site familiarity or experience with behavioral health tools such as PHQ2/9).		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Identify primary care sites that will provide co-located services.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Identify potential regulatory issues associated with co-location of Primary Care and Behavioral Health services. Create mitigation plan for regulatory issues including applying for existing DSRIP regulatory waivers, as appropriate. Escalate regulatory concerns to State Agencies and other stakeholders, as needed.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Convene Clinical Leadership Team to define PPS-wide protocols for co-located behavioral health services at primary care practice sites, including staffing model and processes for interdisciplinary team communication. Synthesize guidelines.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 10: Obtain input from PAC on protocols for co-located behavioral health services at primary care practice sites. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 11: Care Models Committee reviews and makes		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York City Health and Hospitals Corporation (PPS ID:52)

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
consensus-driven recommendation on protocols for co-located behavioral health services at primary care practice sites.										
Task Step 12: Through Hub-based planning process, refine protocols for co-located behavioral health services at primary care practice sites.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 13: Identify hiring needs to support co-located behavioral health services at primary care practice sites.		Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 14: Define PPS training and onboarding needs on protocols for co-located behavioral health services at primary care practice sites.		Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 15: Develop curriculum for training and onboarding on protocols for co-located behavioral health services at primary care practice sites; identify training resources and create training plan.		Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 16: Launch and roll out training and onboarding program.		Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 17: Pilot and roll-out co-location of behavioral health services at participating PCMH sites. Monitor roll-out and refine, as needed.		Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 1	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Coordinated evidence-based care protocols are in place, including medication management and care engagement processes.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize standards of care and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co-develop or coordinate standards of care, as appropriate.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Define PPS training needs on evidence-based standards of care.		Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Develop curriculum for training on evidence-based standards of care.		Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Monitor roll out of protocols and refine as needed through Care Models Subcommittee.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	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	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Policies and procedures are in place to facilitate and document completion of screenings.		Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as		Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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
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.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Assess existing provider capabilities to document preventive care screening and warm hand-off in EHR. Provide guidance to partners on EHR documentation.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Define process to complete and document preventive care screening and warm hand-off in co-located sites.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Define PPS training needs on process to complete and document preventive care screening and warm hand-off in co-located sites. For example: training needs may include provider (re)training, supervision, and skills training (e.g., motivational interviewing, behavioral activation)		Project		In Progress	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 4: Develop curriculum for training on process to complete and document preventive care screening and warm hand-off in co-located sites.		Project		In Progress	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 5: Launch and roll-out training program.		Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Step 6: Monitor roll out and refine process as needed.		Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 1	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 1: Determine IT infrastructure needed to support patient identification and tracking.										
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Complete training on and deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Co-locate primary care services at behavioral health sites.	Model 2	Project	N/A	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 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	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Primary care services are co-located within behavioral Health practices and are available.		Provider	Mental Health	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Define process by which to prioritize behavioral health sites for co-located primary care services (e.g., based on patient need, site readiness, need for modifications to physical plant / site).		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Identify behavioral health sites that will provide co-located services.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.		Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Conduct a gap analysis by key PCMH care model		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

New York City Health and Hospitals Corporation (PPS ID:52)

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
domain across eligible practices and determine cost and feasibility of closing gaps.										
Task Step 5: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.		Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Identify potential regulatory issues associated with co-location of Primary Care and Behavioral Health services. Create mitigation plan for regulatory issues including applying for existing DSRIP regulatory waivers, as appropriate. Escalate regulatory concerns to State Agencies and other stakeholders, as needed.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Convene Clinical Leadership Team to define PPS-wide protocols for co-located primary care services at behavioral health sites, including staffing model and processes for interdisciplinary team communication. Synthesize guidelines.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 10: Obtain input from PAC on protocols for co-located primary care services at behavioral health sites. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task		Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 11: Care Models Committee reviews and makes consensus-driven recommendation on protocols for co-located primary care services at behavioral health sites.										
Task Step 12: Through Hub-based planning process, refine protocols for co-located primary care services at behavioral health sites.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 13: Identify hiring needs to support co-located primary care services at behavioral health sites.		Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 14: Define PPS training and onboarding needs on protocols for co-located primary care services at behavioral health sites.		Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 15: Develop curriculum for training and onboarding on protocols for co-located primary care services at behavioral health sites; identify training resources and create training plan.		Project		In Progress	10/01/2016	09/30/2017	10/01/2016	09/30/2017	09/30/2017	DY3 Q2
Task Step 16: Launch and roll out training and onboarding program.		Project		In Progress	04/01/2017	03/31/2019	04/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Step 17: Pilot and roll-out co-location of primary care services at participating behavioral health sites. Monitor roll-out and refine, as needed.		Project		In Progress	04/01/2017	03/31/2019	04/01/2017	03/31/2019	03/31/2019	DY4 Q4
Milestone #6 Develop collaborative evidence-based standards of care including medication management and care engagement process.	Model 2	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Regularly scheduled formal meetings are held to develop collaborative care practices.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	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	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize standards of care and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co-develop or coordinate standards of care, as appropriate.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Define PPS training needs on evidence-based standards of care.		Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Develop curriculum for training on evidence-based standards of care.		Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Monitor roll out of protocols and refine as needed through Care Models Subcommittee.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	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	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Screenings are conducted for all patients. Process workflows and operational protocols are in place to implement and document screenings.		Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Screenings are documented in Electronic Health Record.		Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task At least 90% of patients receive screenings at the		Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
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.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Step 4: Launch and roll-out training program.		Project		In Progress	07/01/2018	03/31/2019	07/01/2018	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Assess existing provider capabilities to document preventive care screening and warm hand-off in EHR. Provide guidance to partners on EHR documentation.		Project		In Progress	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 2: Define process to complete and document preventive care screening and warm hand-off in co-located sites.		Project		In Progress	07/01/2017	03/31/2018	07/01/2017	03/31/2018	03/31/2018	DY3 Q4
Task Step 3: Define PPS training needs on process to complete and document preventive care screening and warm hand-off in co-located sites.		Project		In Progress	04/01/2018	06/30/2018	04/01/2018	06/30/2018	06/30/2018	DY4 Q1
Task Step 4: Develop curriculum for training on process to complete and document preventive care screening and warm hand-off in co-located sites.		Project		In Progress	04/01/2018	06/30/2018	04/01/2018	06/30/2018	06/30/2018	DY4 Q1
Task Step 5: Launch and roll-out training program for PCMH staff and other team members.		Project		In Progress	07/01/2018	03/31/2019	07/01/2018	03/31/2019	03/31/2019	DY4 Q4
Task Step 6: Monitor roll out and refine process as needed.		Project		In Progress	07/01/2018	03/31/2019	07/01/2018	03/31/2019	03/31/2019	DY4 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 2	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Determine IT infrastructure needed to support patient identification and tracking.		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #9 Implement IMPACT Model at Primary Care Sites.	Model 3	Project	N/A	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task PPS has implemented IMPACT Model at Primary Care Sites.		Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2019	10/01/2015	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Define process by which to prioritize primary care sites for implementation of IMPACT model (e.g., based on patient need, site readiness including readiness for 2014 NCQA Level 3 PCMH / Advanced Primary Care Model standards).		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Work with partners to document behavioral health screening and services already provided at PPS primary care sites, including primary care sites that have already implemented IMPACT model.		Project		In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 3: Identify primary care sites that will implement IMPACT model.		Project		In Progress	10/01/2015	06/30/2017	10/01/2015	06/30/2017	06/30/2017	DY3 Q1
Task Step 4: Define PPS training needs on IMPACT model and collaborative care standards.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Develop curriculum for training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 6: Launch and roll out training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Launch and roll-out IMPACT model – including collaborative care standards - at participating primary care sites. For sites that have already implemented IMPACT model, design and implement improvement methodologies.		Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 8: Monitor roll out of IMPACT model and collaborative care standards, ensuring compliance with program standards. Make refinements to standards as needed.		Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 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	In Progress	04/01/2016	03/31/2017	04/01/2016	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 to facilitate collaboration between primary care physician and care manager.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Policies and procedures include process for consulting with Psychiatrist.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines.		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize guidelines and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Coordinate with other PPSs to adapt/develop training materials and curricula, as appropriate.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Review and consensus-driven recommendation by Care Models Subcommittee.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Monitor and refine as needed.		Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.	Model 3	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 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		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: (For participating sites) Assess PPS primary care sites for current appropriate staffing resources to fulfill depression care management role.		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Identify or recruit Depression Care Manager for sites participating in IMPACT model, ensuring appropriate skill set.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 3: Define PPS training and performance-monitoring needs for Depression Care Managers on IMPACT model and collaborative care standards.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Develop curriculum for training program.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Launch and roll out training program for PCMH staff and other team members.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Conduct periodic review of Depression Care Manager model to ensure compliance with IMPACT program standards. Make refinements as needed.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Designate a Psychiatrist meeting requirements of the	Model 3	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.		Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: (For participating sites) Assess PPS primary care sites for current appropriate staffing resources for Psychiatrist(s).		Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Identify or recruit Psychiatrist for sites participating in IMPACT model.		Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #13 Measure outcomes as required in the IMPACT Model.	Model 3	Project	N/A	In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).		Project		In Progress	07/01/2016	03/31/2019	07/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task Step 1: Define process to measure outcomes, including process to complete and document preventive care screening in established project sites.		Project		In Progress	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Develop curriculum and training for staff.		Project		In Progress	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 3: Identify training resources and create training plan.		Project		In Progress	04/01/2017	06/30/2017	04/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 4: Launch and roll-out training program.		Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Task Step 5: Measure outcomes and implement improvement methodologies at sites participating in IMPACT model.		Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Milestone #14 Provide "stepped care" as required by the IMPACT Model.	Model 3	Project	N/A	In Progress	04/01/2016	03/31/2019	04/01/2016	03/31/2019	03/31/2019	DY4 Q4
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.		Project		In Progress	04/01/2016	03/31/2019	04/01/2016	03/31/2019	03/31/2019	DY4 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for provision of "stepped care".		Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize guidelines on provision of "stepped care" and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders).		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Review and consensus-driven recommendation by Care Models subcommittee.		Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Define PPS training needs on provision of "stepped care." Develop curriculum for training on provision of "stepped care."		Project		In Progress	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 5: Identify training resources and develop training plan.		Project		In Progress	01/01/2017	06/30/2017	01/01/2017	06/30/2017	06/30/2017	DY3 Q1
Task Step 6: Launch and roll-out IMPACT model at participating primary care sites, including training		Project		In Progress	07/01/2017	03/31/2019	07/01/2017	03/31/2019	03/31/2019	DY4 Q4
Milestone #15 Use EHRs or other technical platforms to track all patients engaged in this project.	Model 3	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task EHR demonstrates integration of medical and behavioral health record within individual patient records.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.		Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine IT infrastructure needed to support patient identification and tracking		Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.		Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.		Project		In Progress	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 Co-locate behavioral health services at primary care practice sites. All participating primary care practices must meet 2014 NCQA level 3 PCMH or Advance Primary Care Model standards by DY 3.										
Task All practices meet NCQA 2014 Level 3 PCMH and/or APCM standards by the end of DY3.	0	0	0	0	0	0	0	63	158	316
Task Behavioral health services are co-located within PCMH/APC practices and are available.	0	0	0	0	0	0	0	17	43	85
Task Step 1: Define process by which to prioritize primary care sites for co-located behavioral health services (e.g., based on patient need, site readiness including readiness for 2014 NCQA Level 3 PCMH / Advanced Primary Care Model standards, site familiarity or experience with behavioral health tools such as PHQ2/9).										
Task Step 2: Identify primary care sites that will provide co-located services.										
Task Step 3: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 4: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.										
Task Step 5: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives,										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
webinars, and/or contracting with outside vendors.										
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.										
Task Step 8: Identify potential regulatory issues associated with co-location of Primary Care and Behavioral Health services. Create mitigation plan for regulatory issues including applying for existing DSRIP regulatory waivers, as appropriate. Escalate regulatory concerns to State Agencies and other stakeholders, as needed.										
Task Step 9: Convene Clinical Leadership Team to define PPS-wide protocols for co-located behavioral health services at primary care practice sites, including staffing model and processes for interdisciplinary team communication. Synthesize guidelines.										
Task Step 10: Obtain input from PAC on protocols for co-located behavioral health services at primary care practice sites. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 11: Care Models Committee reviews and makes consensus-driven recommendation on protocols for co-located behavioral health services at primary care practice sites.										
Task Step 12: Through Hub-based planning process, refine protocols for co-located behavioral health services at primary care practice sites.										
Task Step 13: Identify hiring needs to support co-located behavioral health services at primary care practice sites.										
Task Step 14: Define PPS training and onboarding needs on protocols for co-located behavioral health services at primary care practice sites.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 15: Develop curriculum for training and onboarding on protocols for co-located behavioral health services at primary care practice sites; identify training resources and create training plan.										
Task Step 16: Launch and roll out training and onboarding program.										
Task Step 17: Pilot and roll-out co-location of behavioral health services at participating PCMH sites. Monitor roll-out and refine, as needed.										
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 Step 1: Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.										
Task Step 2: Synthesize standards of care and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co-develop or coordinate standards of care, as appropriate.										
Task Step 3: Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.										
Task Step 4: Define PPS training needs on evidence-based standards of care.										
Task Step 5: Develop curriculum for training on evidence-based standards of care.										
Task Step 6: Launch and roll out training program.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 7: Monitor roll out of protocols and refine as needed through Care Models Subcommittee.										
Milestone #3 Conduct preventive care screenings, including behavioral health screenings (PHQ-2 or 9 for those screening positive, SBIRT) implemented for all patients to identify unmet needs.										
Task Policies and procedures are in place to facilitate and document completion of screenings.										
Task Screenings are documented in Electronic Health Record.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Positive screenings result in "warm transfer" to behavioral health provider as measured by documentation in Electronic Health Record.	0	0	0	0	0	0	0	0	0	0
Task Step 1: Assess existing provider capabilities to document preventive care screening and warm hand-off in EHR. Provide guidance to partners on EHR documentation.										
Task Step 2: Define process to complete and document preventive care screening and warm hand-off in co-located sites.										
Task Step 3: Define PPS training needs on process to complete and document preventive care screening and warm hand-off in co-located sites. For example: training needs may include provider (re)training, supervision, and skills training (e.g., motivational interviewing, behavioral activation)										
Task Step 4: Develop curriculum for training on process to complete and document preventive care screening and warm hand-off in co-located sites.										
Task Step 5: Launch and roll-out training program.										
Task Step 6: Monitor roll out and refine process as needed.										
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.										
Task Step 1: Determine IT infrastructure needed to support patient identification and tracking.										
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.										
Task Step 3: Complete training on and deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.										
Milestone #5 Co-locate primary care services at behavioral health sites.										
Task PPS has achieved NCQA 2014 Level 3 PCMH or Advanced Primary Care Model Practices by the end of DY3.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Primary care services are co-located within behavioral Health practices and are available.	0	0	0	0	0	0	0	0	0	0
Task Step 1: Define process by which to prioritize behavioral health sites for co-located primary care services (e.g., based on patient need, site readiness, need for modifications to physical plant / site).										
Task Step 2: Identify behavioral health sites that will provide co-located services.										
Task Step 3: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 4: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.										
Task Step 8: Identify potential regulatory issues associated with co-location of Primary Care and Behavioral Health services. Create mitigation plan for regulatory issues including applying for existing DSRIP regulatory waivers, as appropriate. Escalate regulatory concerns to State Agencies and other stakeholders, as needed.										
Task Step 9: Convene Clinical Leadership Team to define PPS-wide protocols for co-located primary care services at behavioral health sites, including staffing model and processes for interdisciplinary team communication. Synthesize guidelines.										
Task Step 10: Obtain input from PAC on protocols for co-located primary care services at behavioral health sites. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 11: Care Models Committee reviews and makes consensus-driven recommendation on protocols for co-located primary care services at behavioral health sites.										
Task Step 12: Through Hub-based planning process, refine protocols for co-located primary care services at behavioral health sites.										
Task Step 13: Identify hiring needs to support co-located primary care services at behavioral health sites.										
Task Step 14: Define PPS training and onboarding needs on protocols for co-located primary care services at behavioral health sites.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 15: Develop curriculum for training and onboarding on protocols for co-located primary care services at behavioral health sites; identify training resources and create training plan.										
Task Step 16: Launch and roll out training and onboarding program.										
Task Step 17: Pilot and roll-out co-location of primary care services at participating behavioral health sites. Monitor roll-out and refine, as needed.										
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 Step 1: Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.										
Task Step 2: Synthesize standards of care and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co-develop or coordinate standards of care, as appropriate.										
Task Step 3: Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.										
Task Step 4: Define PPS training needs on evidence-based standards of care.										
Task Step 5: Develop curriculum for training on evidence-based standards of care.										
Task Step 6: Launch and roll out training program.										
Task Step 7: Monitor roll out of protocols and refine as needed through										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Care Models Subcommittee.										
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	0	0	0	0	0	0	0	0	0
Task Step 4: Launch and roll-out training program.										
Task Step 1: Assess existing provider capabilities to document preventive care screening and warm hand-off in EHR. Provide guidance to partners on EHR documentation.										
Task Step 2: Define process to complete and document preventive care screening and warm hand-off in co-located sites.										
Task Step 3: Define PPS training needs on process to complete and document preventive care screening and warm hand-off in co-located sites.										
Task Step 4: Develop curriculum for training on process to complete and document preventive care screening and warm hand-off in co-located sites.										
Task Step 5: Launch and roll-out training program for PCMH staff and other team members.										
Task Step 6: Monitor roll out and refine process as needed.										
Milestone #8 Use EHRs or other technical platforms to track all patients										

New York City Health and Hospitals Corporation (PPS ID:52)

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
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 Step 1: Determine IT infrastructure needed to support patient identification and tracking.										
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.										
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.										
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
Task Step 1: Define process by which to prioritize primary care sites for implementation of IMPACT model (e.g., based on patient need, site readiness including readiness for 2014 NCQA Level 3 PCMH / Advanced Primary Care Model standards).										
Task Step 2: Work with partners to document behavioral health screening and services already provided at PPS primary care sites, including primary care sites that have already implemented IMPACT model.										
Task Step 3: Identify primary care sites that will implement IMPACT model.										
Task Step 4: Define PPS training needs on IMPACT model and collaborative care standards.										
Task Step 5: Develop curriculum for training program.										
Task Step 6: Launch and roll out training program.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 7: Launch and roll-out IMPACT model – including collaborative care standards - at participating primary care sites. For sites that have already implemented IMPACT model, design and implement improvement methodologies.										
Task Step 8: Monitor roll out of IMPACT model and collaborative care standards, ensuring compliance with program standards. Make refinements to standards as needed.										
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines.										
Task Step 2: Synthesize guidelines and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Coordinate with other PPSs to adapt/develop training materials and curricula, as appropriate.										
Task Step 3: Review and consensus-driven recommendation by Care Models Subcommittee.										
Task Step 4: Monitor and refine as needed.										
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										

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Task Step 1: (For participating sites) Assess PPS primary care sites for current appropriate staffing resources to fulfill depression care management role.										
Task Step 2: Identify or recruit Depression Care Manager for sites participating in IMPACT model, ensuring appropriate skill set.										
Task Step 3: Define PPS training and performance-monitoring needs for Depression Care Managers on IMPACT model and collaborative care standards.										
Task Step 4: Develop curriculum for training program.										
Task Step 5: Launch and roll out training program for PCMH staff and other team members.										
Task Step 6: Conduct periodic review of Depression Care Manager model to ensure compliance with IMPACT program standards. Make refinements as needed.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task Step 1: (For participating sites) Assess PPS primary care sites for current appropriate staffing resources for Psychiatrist(s).										
Task Step 2: Identify or recruit Psychiatrist for sites participating in IMPACT model.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task At least 90% of patients receive screenings at the established project sites (Screenings are defined as industry standard questionnaires such as PHQ-2 or 9 for those screening positive, SBIRT).										
Task Step 1: Define process to measure outcomes, including process										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
to complete and document preventive care screening in established project sites.										
Task Step 2: Develop curriculum and training for staff.										
Task Step 3: Identify training resources and create training plan.										
Task Step 4: Launch and roll-out training program.										
Task Step 5: Measure outcomes and implement improvement methodologies at sites participating in IMPACT model.										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for provision of "stepped care".										
Task Step 2: Synthesize guidelines on provision of "stepped care" and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders).										
Task Step 3: Review and consensus-driven recommendation by Care Models subcommittee.										
Task Step 4: Define PPS training needs on provision of "stepped care." Develop curriculum for training on provision of "stepped care."										
Task Step 5: Identify training resources and develop training plan.										
Task Step 6: Launch and roll-out IMPACT model at participating primary care sites, including training										
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										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Determine IT infrastructure needed to support patient identification and tracking										
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.										
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.										

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.	474	632	632	632	632	632	632	632	632	632
Task Behavioral health services are co-located within PCMH/APC practices and are available.	128	170	170	170	170	170	170	170	170	170
Task Step 1: Define process by which to prioritize primary care sites for co-located behavioral health services (e.g., based on patient need, site readiness including readiness for 2014 NCQA Level 3 PCMH / Advanced Primary Care Model standards, site familiarity or experience with behavioral health tools such as PHQ2/9).										
Task Step 2: Identify primary care sites that will provide co-located services.										
Task Step 3: As part of current-state assessment, develop definitive list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 4: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and										

New York City Health and Hospitals Corporation (PPS ID:52)

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
feasibility of closing gaps.										
Task Step 5: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.										
Task Step 8: Identify potential regulatory issues associated with co-location of Primary Care and Behavioral Health services. Create mitigation plan for regulatory issues including applying for existing DSRIP regulatory waivers, as appropriate. Escalate regulatory concerns to State Agencies and other stakeholders, as needed.										
Task Step 9: Convene Clinical Leadership Team to define PPS-wide protocols for co-located behavioral health services at primary care practice sites, including staffing model and processes for interdisciplinary team communication. Synthesize guidelines.										
Task Step 10: Obtain input from PAC on protocols for co-located behavioral health services at primary care practice sites. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 11: Care Models Committee reviews and makes consensus-driven recommendation on protocols for co-located behavioral health services at primary care practice sites.										
Task Step 12: Through Hub-based planning process, refine protocols for co-located behavioral health services at primary care practice sites.										
Task Step 13: Identify hiring needs to support co-located behavioral health services at primary care practice sites.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 14: Define PPS training and onboarding needs on protocols for co-located behavioral health services at primary care practice sites.										
Task Step 15: Develop curriculum for training and onboarding on protocols for co-located behavioral health services at primary care practice sites; identify training resources and create training plan.										
Task Step 16: Launch and roll out training and onboarding program.										
Task Step 17: Pilot and roll-out co-location of behavioral health services at participating PCMH sites. Monitor roll-out and refine, as needed.										
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 Step 1: Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.										
Task Step 2: Synthesize standards of care and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co-develop or coordinate standards of care, as appropriate.										
Task Step 3: Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.										
Task Step 4: Define PPS training needs on evidence-based standards of care.										
Task Step 5: Develop curriculum for training on evidence-based										

New York City Health and Hospitals Corporation (PPS ID:52)

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
standards of care.										
Task Step 6: Launch and roll out training program.										
Task Step 7: Monitor roll out of protocols and refine as needed through Care Models Subcommittee.										
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	63	158	316	474	632	632	632	632	632
Task Step 1: Assess existing provider capabilities to document preventive care screening and warm hand-off in EHR. Provide guidance to partners on EHR documentation.										
Task Step 2: Define process to complete and document preventive care screening and warm hand-off in co-located sites.										
Task Step 3: Define PPS training needs on process to complete and document preventive care screening and warm hand-off in co-located sites. For example: training needs may include provider (re)training, supervision, and skills training (e.g., motivational interviewing, behavioral activation)										
Task Step 4: Develop curriculum for training on process to complete and document preventive care screening and warm hand-off in co-located sites.										
Task Step 5: Launch and roll-out training program.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 6: Monitor roll out and refine process as needed.										
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 Step 1: Determine IT infrastructure needed to support patient identification and tracking.										
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.										
Task Step 3: Complete training on and deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.										
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	63	158	316	474	632	632	632	632	632
Task Primary care services are co-located within behavioral Health practices and are available.	0	63	158	316	474	632	632	632	632	632
Task Primary care services are co-located within behavioral Health practices and are available.	0	17	43	85	128	170	170	170	170	170
Task Step 1: Define process by which to prioritize behavioral health sites for co-located primary care services (e.g., based on patient need, site readiness, need for modifications to physical plant / site).										
Task Step 2: Identify behavioral health sites that will provide co-located services.										
Task Step 3: As part of current-state assessment, develop definitive										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
list of PCMH-eligible practices and recognition status of each eligible practice.										
Task Step 4: Conduct a gap analysis by key PCMH care model domain across eligible practices and determine cost and feasibility of closing gaps.										
Task Step 5: Identify cost-effective options to support partners in evaluating and mapping clinical workflows to meet appropriate PCMH standards. These may include learning collaboratives, webinars, and/or contracting with outside vendors.										
Task Step 6: Develop and communicate plan and timeline to ensure that all PCMH-eligible practices meet PCMH 2014 Level 3 recognition by the end of DY3, taking into account differing levels of readiness among practices.										
Task Step 7: Establish ongoing reporting and provider communication process to track progress against PCMH readiness plan, including progress against plan to ensure certified EHRs are in place for all eligible providers.										
Task Step 8: Identify potential regulatory issues associated with co-location of Primary Care and Behavioral Health services. Create mitigation plan for regulatory issues including applying for existing DSRIP regulatory waivers, as appropriate. Escalate regulatory concerns to State Agencies and other stakeholders, as needed.										
Task Step 9: Convene Clinical Leadership Team to define PPS-wide protocols for co-located primary care services at behavioral health sites, including staffing model and processes for interdisciplinary team communication. Synthesize guidelines.										
Task Step 10: Obtain input from PAC on protocols for co-located primary care services at behavioral health sites. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 11: Care Models Committee reviews and makes consensus-driven recommendation on protocols for co-located primary care services at behavioral health sites.										
Task Step 12: Through Hub-based planning process, refine protocols for co-located primary care services at behavioral health sites.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 13: Identify hiring needs to support co-located primary care services at behavioral health sites.										
Task Step 14: Define PPS training and onboarding needs on protocols for co-located primary care services at behavioral health sites.										
Task Step 15: Develop curriculum for training and onboarding on protocols for co-located primary care services at behavioral health sites; identify training resources and create training plan.										
Task Step 16: Launch and roll out training and onboarding program.										
Task Step 17: Pilot and roll-out co-location of primary care services at participating behavioral health sites. Monitor roll-out and refine, as needed.										
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 Step 1: Convene Clinical Leadership Team to define evidence-based standards of care, including medication management and care engagement process.										
Task Step 2: Synthesize standards of care and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Work with collaborating PPSs to identify opportunities to co-develop or coordinate standards of care, as appropriate.										
Task Step 3: Review and consensus-driven recommendation of standards of care by Care Models Subcommittee.										
Task Step 4: Define PPS training needs on evidence-based standards of care.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Develop curriculum for training on evidence-based standards of care.										
Task Step 6: Launch and roll out training program.										
Task Step 7: Monitor roll out of protocols and refine as needed through Care Models Subcommittee.										
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	63	158	316	474	632	632	632	632	632
Task Step 4: Launch and roll-out training program.										
Task Step 1: Assess existing provider capabilities to document preventive care screening and warm hand-off in EHR. Provide guidance to partners on EHR documentation.										
Task Step 2: Define process to complete and document preventive care screening and warm hand-off in co-located sites.										
Task Step 3: Define PPS training needs on process to complete and document preventive care screening and warm hand-off in co-located sites.										
Task Step 4: Develop curriculum for training on process to complete and document preventive care screening and warm hand-off in co-located sites.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Launch and roll-out training program for PCMH staff and other team members.										
Task Step 6: Monitor roll out and refine process as needed.										
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 Step 1: Determine IT infrastructure needed to support patient identification and tracking.										
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.										
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.										
Milestone #9 Implement IMPACT Model at Primary Care Sites.										
Task PPS has implemented IMPACT Model at Primary Care Sites.	0	63	158	316	474	632	632	632	632	632
Task Step 1: Define process by which to prioritize primary care sites for implementation of IMPACT model (e.g., based on patient need, site readiness including readiness for 2014 NCQA Level 3 PCMH / Advanced Primary Care Model standards).										
Task Step 2: Work with partners to document behavioral health screening and services already provided at PPS primary care sites, including primary care sites that have already implemented IMPACT model.										
Task Step 3: Identify primary care sites that will implement IMPACT model.										
Task										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 4: Define PPS training needs on IMPACT model and collaborative care standards.										
Task Step 5: Develop curriculum for training program.										
Task Step 6: Launch and roll out training program.										
Task Step 7: Launch and roll-out IMPACT model – including collaborative care standards - at participating primary care sites. For sites that have already implemented IMPACT model, design and implement improvement methodologies.										
Task Step 8: Monitor roll out of IMPACT model and collaborative care standards, ensuring compliance with program standards. Make refinements to standards as needed.										
Milestone #10 Utilize IMPACT Model collaborative care standards, including developing coordinated evidence-based care standards and policies and procedures for care engagement.										
Task Coordinated evidence-based care protocols are in place, including a medication management and care engagement process to facilitate collaboration between primary care physician and care manager.										
Task Policies and procedures include process for consulting with Psychiatrist.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines.										
Task Step 2: Synthesize guidelines and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders). Coordinate with other PPSs to adapt/develop training materials and curricula, as appropriate.										
Task Step 3: Review and consensus-driven recommendation by Care Models Subcommittee.										
Task Step 4: Monitor and refine as needed.										
Milestone #11 Employ a trained Depression Care Manager meeting requirements of the IMPACT model.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 qualified Depression Care Manager (can be a nurse, social worker, or psychologist) as identified in Electronic Health Records.										
Task Depression care manager meets requirements of IMPACT model, including coaching patients in behavioral activation, offering course in counseling, monitoring depression symptoms for treatment response, and completing a relapse prevention plan.										
Task Step 1: (For participating sites) Assess PPS primary care sites for current appropriate staffing resources to fulfill depression care management role.										
Task Step 2: Identify or recruit Depression Care Manager for sites participating in IMPACT model, ensuring appropriate skill set.										
Task Step 3: Define PPS training and performance-monitoring needs for Depression Care Managers on IMPACT model and collaborative care standards.										
Task Step 4: Develop curriculum for training program.										
Task Step 5: Launch and roll out training program for PCMH staff and other team members.										
Task Step 6: Conduct periodic review of Depression Care Manager model to ensure compliance with IMPACT program standards. Make refinements as needed.										
Milestone #12 Designate a Psychiatrist meeting requirements of the IMPACT Model.										
Task All IMPACT participants in PPS have a designated Psychiatrist.										
Task Step 1: (For participating sites) Assess PPS primary care sites for current appropriate staffing resources for Psychiatrist(s).										
Task Step 2: Identify or recruit Psychiatrist for sites participating in IMPACT model.										
Milestone #13 Measure outcomes as required in the IMPACT Model.										
Task										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
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 Step 1: Define process to measure outcomes, including process to complete and document preventive care screening in established project sites.										
Task Step 2: Develop curriculum and training for staff.										
Task Step 3: Identify training resources and create training plan.										
Task Step 4: Launch and roll-out training program.										
Task Step 5: Measure outcomes and implement improvement methodologies at sites participating in IMPACT model.										
Milestone #14 Provide "stepped care" as required by the IMPACT Model.										
Task In alignment with the IMPACT model, treatment is adjusted based on evidence-based algorithm that includes evaluation of patient after 10-12 weeks after start of treatment plan.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for provision of "stepped care".										
Task Step 2: Synthesize guidelines on provision of "stepped care" and obtain input from stakeholders (e.g. PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders).										
Task Step 3: Review and consensus-driven recommendation by Care Models subcommittee.										
Task Step 4: Define PPS training needs on provision of "stepped care." Develop curriculum for training on provision of "stepped care."										
Task Step 5: Identify training resources and develop training plan.										
Task Step 6: Launch and roll-out IMPACT model at participating primary care sites, including training										
Milestone #15										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
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 Step 1: Determine IT infrastructure needed to support patient identification and tracking										
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.										
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.										

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.	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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 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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.

One of the required interventions of the Cardiovascular Project is to ensure that attributed patients are able to have a drop-in blood pressure check with no copay. We anticipate a risk associated with the administrative and nursing capacity. Larger clinics may have a more complex workflow in which to integrate this service and smaller clinics may lack capacity and staffing. To mitigate this risk we intend to work with ambulatory care practices to determine the specific barriers to implementation and develop strategies to overcome the barriers. Patients also don't come in for blood pressure checks due to transportation costs, time required, missed work time etc. To mitigate this risk, we will use home blood pressure monitors to assess patient's blood pressure with reporting via phone.

We also expect risks associated with effective engagement of chronically ill patients over the long term, particularly with regard to behavior change. To mitigate this risk we intend to deploy peer educators and care managers to support patients, with heavy reliance on the recommended evidence-based Stanford Model.

The CVD project requires clinicians to prescribe once-daily regimens or fixed-dose combination pills when appropriate. The second major risk to the project is the potential for Medicaid managed care plans to not cover either the once-daily regimen or fixed dose combination pills. Lack of coverage for the pills would likely result in a lack of adherence. To mitigate this risk, we intend to work collaboratively with other PPSs and managed care plans to optimize and unify the formulary for proven CV medications.

We have also identified risks related to health IT. Our ability to implement and report on metrics related to the project are dependent on existing registries and interoperability. To mitigate this risk we will identify specific IT requirements of the project – such as using the registry to identify existing patients who meet project inclusion criteria – and determine the best way to incorporate this functionality.

The CVD project also requires that 80% of providers be engaged. We believe engaging the majority of primary care providers (PCPs) within the PPS in this project presents a risk, given that PCPs often have very challenging schedules and making time for new quality improvement or practice transformation efforts can be challenging. To mitigate this risk, we intend to work closely with PCPs to provide education about the importance of the project. We will also identify clinical champions, as needed, to promote engagement. Our PPS may also make available clinical and practice transformation support to practices that are either lower performers or that have demonstrated limited engagement in implementation. Finally, we will use the contracting process as a lever to require PPS partners to meet project requirements.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	47,329

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
0	0		0	0.00%

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
nholder9	Baseline or Performance Documentation	52_PMDL4215_1_3_20160125162405_OneCity_Health_Patient_Engagement_Commitments.pdf	Please see page 6 with the patient engagement speed commitments for this project, which begin in DY2 Q1.	01/25/2016 04:25 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Project Requirements (Milestone/Task Name)	Reporting Level	Provider Type	Status	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone #1 Implement program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented program to improve management of cardiovascular disease using evidence-based strategies in the ambulatory and community care setting.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide programs for improving management of cardiovascular disease (CVD) using evidence-based strategies in ambulatory and community care settings.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize programs for improving management of CVD and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on programs for improving management of CVD.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine programs for improving management of CVD through Hub-based planning process.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
understand PPS capacity for implementing evidence-based strategies for improved care of CVD. Educate partners on PRAT and roll out PRAT.									
Task Step 6: Analyze current state baseline data to assess existing provider capabilities for implementing evidence-based strategies for improved care of CVD. Segment providers.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Identify staff needed (e.g. registry coordinator, outreach manager, data manager, pharmacist, care manager, collaborative care nurses) and location (on-site vs. centralized support), roles/responsibilities, local practitioner champions and processes for implementing evidence-based strategies for improving management of CVD. As implementation progresses, modify as needed.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Roll out, monitor, and refine rollout of evidence-based strategies for improving management of CVD, as needed.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information exchange/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Practitioner - Non-Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	Provider	Safety Net Mental Health	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses alerts and secure messaging functionality.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 systems with local health information exchange and among clinical partners.									
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #3 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM by the end of 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	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 Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.	Project		Completed	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Develop target completion dates for each provider to obtain a certified EHR system.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners. Refine as needed.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #4 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine IT infrastructure needed to support patient identification and tracking.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop plan to create/update patient registries to support patient identification and outreach for those with CVD conditions. Develop data reporting plan to assess data completeness of relevant EHR fields.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	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	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has implemented an automated scheduling system to	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
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.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine IT infrastructure needed to support patient identification, patient tracking, and provider prompts that facilitate tobacco control protocols, including capacity for periodic self-audits.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop plan to deploy patient registries and training requirements to support patient identification, patient tracking, and provider prompts.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Complete deployment of patient registries to support patient identification, patient tracking, and provider prompts.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Define PPS training needs on the use of EHRs in tobacco control protocols, develop training curriculum, and write training materials.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Create training curriculum and create training plan.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Launch and roll out training program on the use of EHRs in tobacco control protocols.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	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	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Practice has adopted treatment protocols aligned with national guidelines, such as the National Cholesterol Education Program (NCEP) or US Preventive Services Task Force (USPSTF).	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for adopting standardized treatment protocols for hypertension and elevated cholesterol that align with national guidelines.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize adoption guidelines and treatment protocols,	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1

New York City Health and Hospitals Corporation (PPS ID:52)

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 obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.									
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on adoption guidelines and treatment protocols.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine adoption guidelines and treatment protocols through Hub-based planning process.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Identify roles, responsibilities, and processes for providing standardized treatment protocols for hypertension and elevated cholesterol.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Establish contracts with partners to follow standardized treatment protocols for hypertension and elevated cholesterol.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Create training curriculum and training plan, and roll out training program.	Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 8: Monitor roll out of treatment protocols and refine as needed.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Clinically Interoperable System is in place for all participating providers.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination teams are in place and include nursing staff, pharmacists, dieticians, community health workers, and Health Home care managers where applicable.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Care coordination processes are in place.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Convene Clinical Leadership Team to define PPS-wide protocols, procedures and workflows for care coordination teams to address lifestyle changes, medication adherence, health literacy issues, and patient self-management.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize care coordination clinical protocols and workflows and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on care coordination protocols and workflows.	Project		On Hold	07/01/2015	06/30/2016	04/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 4: Refine care coordination guidelines through Hub-based planning process.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand partner capacity for coordinating care with other PPS partners to help patients manage lifestyle changes, adhere to medication as prescribed, and self-manage their care. Educate partners on PRAT and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 6: Analyze current state baseline data to assess existing provider capabilities to coordinate care with other providers. Segment providers.	Project		In Progress	07/01/2015	12/31/2015	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 7: Identify staffing needs, roles, responsibilities, and processes of delivering coordinated care.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 8: Contract with partners as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 9: Create training curriculum and training plan, and roll out training program	Project		In Progress	07/01/2016	12/31/2016	07/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 10: Roll out care coordination teams, monitor performance,	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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 refine as needed.									
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on care coordination protocols.	Project		In Progress			10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All primary care practices in the PPS provide follow-up blood pressure checks without copayment or advanced appointments.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Assess existing provider capabilities to provide follow-up blood pressure checks without a copayment or advanced appointment.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Define process to provide follow-up blood pressure checks without a copayment or advanced appointment.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Define PPS training needs on process to provide follow-up blood pressure checks without a copayment or advanced appointment.	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Develop curriculum for training on process to provide follow-up blood pressure checks without a copayment or advanced appointment.	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Launch and roll-out training program.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 6: Monitor roll out and refine process as needed.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place to ensure blood pressure measurements are taken correctly with the correct equipment.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide protocol on blood pressure measuring and recording.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Synthesize guidelines on blood pressure measuring and recording and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Refine guidelines for measuring and recording blood pressure through Hub-based planning process.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Roll out training and monitor process for measuring and recording blood pressure monitoring. Refine as needed.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Determine IT infrastructure needed to identify patients seen routinely with repeated elevated blood pressures in the medical record but no diagnosis.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Determine clinical review process and care team roles in identifying patients needing outreach and scheduling follow up BP visit.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification, tracking, and automated scheduling of follow-up visits. Plan should include training requirements.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Develop a training program, roll out training program, and track those trained on identification of patients with undiagnosed hypertension.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Complete deployment of CCMS and related registries to support patient identification, tracking, and automated scheduling of follow-up visits.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 6: Roll out, monitor and refine protocol for identifying those at-risk of HTN and use of CCMS as needed.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has protocols in place for determining preferential drugs based on ease of medication adherence where there are no other significant non-differentiating factors.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide medication algorithm based on ease of medication adherence, efficacy, ease of titration, managed care plan formularies, and other relevant criteria.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on medication algorithm based on ease of medication adherence.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine medication algorithm based on ease of medication adherence through Hub-based planning process.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Assess current-state Medicaid Managed Care Organizations (MCO) pharmacy benefits as they relate to medication algorithm.	Project		In Progress	01/01/2016	12/31/2016	01/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 6: Identify opportunities to collaborate with MCOs on pharmacy benefits that will support implementation of medication algorithm.									
Task Step 7: Roll out, monitor implementation of medication algorithm and refine as needed.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Self-management goals are documented in the clinical record.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on person-centered methods that include documentation of self-management goals.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for documenting self-management goals in medical records.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize guidelines and IT requirements for documenting self-management goals in medical records and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for documenting self-management goals in medical records.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine guidelines for documenting self-management goals in medical records through Hub-based planning process.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs, for documenting self-management goals through person-centered methods.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop curriculum for training on person-centered methods that include documenting self-management goals; identify training resources and create training plan.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 7: Launch and roll out training program.									
Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Project	N/A	In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS provides periodic training to staff on warm referral and follow-up process.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Agreements are in place with community-based organizations and process is in place to facilitate feedback to and from community organizations.	Project		In Progress	07/01/2015	03/31/2018	07/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Through Hub-based planning process, identify and implement agreements with community-based resources to refer patients to and distribute resource lists.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Define PPS training needs for making warm referrals and the follow-up process.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Develop curriculum for training on making warm referrals and the follow-up process.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Identify training resources and create training plan.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Launch and roll out training program.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 6: Monitor and track referrals, follow-ups, documentation, and feedback, and refine process as needed.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed and implemented protocols for home blood pressure monitoring.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 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.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide clinical protocol and workflow for home blood pressure monitoring and follow-up support.	Project		In Progress	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Synthesize clinical protocol and workflow for home blood pressure monitoring and follow-up support, and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on clinical protocols and workflow for home blood pressure monitoring and follow-up support.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Through Hub-based planning process, refine guidelines for home blood pressure monitoring and follow-up support.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Identify team capacity and roles, identify equipment vendor, create plan for equipment supply distribution and tracking, determine IT needs for patient tracking.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Define PPS training needs for making warm referrals and following up on referrals.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Develop curriculum for training on making warm referrals and the follow-up process.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 8: Identify training resources, create training plan, launch training program.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 9: Monitor referrals, follow-ups, and documentation; refine protocol as needed.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #15	Project	N/A	In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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
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.	Project		In Progress	07/01/2015	03/31/2017	07/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Through Hub-based planning process, refine guidelines for identifying and reaching patients with hypertension.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Determine IT infrastructure/registry and reporting needed to identify patients with hypertension and automatically scheduling follow-up appointments.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification, tracking, and automated scheduling of follow-up visits. Plan should include training requirements.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Complete deployment of CCMS and related registries to support patient identification, tracking, and automated scheduling of follow-up visits.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Monitor and refine protocol for identifying and reaching patients with hypertension, and use of CCMS as needed.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed referral and follow-up process and adheres to process.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define guidelines for referring smokers to the Quitline.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
driven recommendation on guidelines for referring smokers to the Quitline.									
Task Step 4: Refine guidelines for referring smokers to the Quitline through Hub-based planning process.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs on guidelines for referring smokers to the Quitline.	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop curriculum for training on guidelines for referring smokers to the Quitline.	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Launch and roll-out training program.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Monitor roll out and refine process as needed.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	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	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has Implemented collection of valid and reliable REAL (Race, Ethnicity, and Language) data and uses the data to target high risk populations, develop improvement plans, and address top health disparities.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has established linkages to health homes for targeted patient populations.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task If applicable, PPS has implemented Stanford Model through partnerships with community-based organizations.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Based on Community Needs Assessment (CNA) and Medicaid Claims and Encounter data (from SIM tool), identify high risk neighborhoods where PPS may deploy "hot spotting" strategies for high risk populations.	Project		In Progress	01/01/2016	06/30/2016	01/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Use Partner Readiness Assessment Tool (PRAT) to understand provider capacity to perform additional actions	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1

New York City Health and Hospitals Corporation (PPS ID:52)

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
towards the better care management for high risk populations in "hot spot" areas.									
Task Step 3: Analyze current state baseline data to assess existing provider capabilities connecting patients to Health Homes, facilitating group visits, implementing the Stanford Model for chronic diseases, and other additional care strategies that benefit high risk populations. Segment providers.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Identify needs, roles, responsibilities, and processes for performance of additional care activities that benefit high-risk populations.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Based on provider assessment and "hot spotting" work, contract with partners as necessary.	Project		In Progress	07/01/2016	03/31/2018	07/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 6: Determine IT infrastructure needed to support patient identification and tracking.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Complete deployment of CCMS and related registries to support patient identification and tracking.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #18 Adopt strategies from the Million Hearts Campaign.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	Provider	Practitioner - Non-Primary Care Provider (PCP)	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million	Provider	Mental Health	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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
Hearts Campaign.									
Task Step 1: Convene Clinical Leadership Team to define guidelines for adopting strategies from the Million Hearts Campaign.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for adopting strategies from the Million Hearts Campaign.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 4: Refine guidelines for adopting strategies from the Million Hearts Campaign through Hub-based planning process.	Project		In Progress	10/01/2015	06/30/2016	10/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Define PPS training needs on guidelines related to strategies from the Million Hearts Campaign.	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Develop curriculum for training on guidelines related to strategies from the Million Hearts Campaign.	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 7: Launch and roll-out training program.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 8: Monitor implementation of policies and procedures that reflect principles and initiatives of the Million Hearts Campaign. Refine as needed.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	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	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has agreement in place with MCO related to coordination of services for high risk populations, including smoking cessation services, hypertension screening, cholesterol screening, and other preventive services relevant to this project.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Review existing MCO contracts to determine gaps in coverage related to coordination of services for high risk	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
populations.									
Task Step 2: Develop agreements to address coverage gaps.	Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 3: Finalize agreements with MCO partners.	Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has engaged at least 80% of their PCPs in this activity.	Provider	Practitioner - Primary Care Provider (PCP)	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand partner capacity to delivery primary care to affected populations. Educate partners on PRAT and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess the number of primary care providers within a PPS. Segment providers.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes for engaging primary care providers.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Contract with primary care providers as needed.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Roll out campaign to engage primary care providers. Monitor number of PCPs in the PPS and revise campaign as needed.	Project		In Progress	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										

New York City Health and Hospitals Corporation (PPS ID:52)

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
ambulatory and community care setting.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide programs for improving management of cardiovascular disease (CVD) using evidence-based strategies in ambulatory and community care settings.										
Task Step 2: Synthesize programs for improving management of CVD and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on programs for improving management of CVD.										
Task Step 4: Refine programs for improving management of CVD through Hub-based planning process.										
Task Step 5: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand PPS capacity for implementing evidence-based strategies for improved care of CVD. Educate partners on PRAT and roll out PRAT.										
Task Step 6: Analyze current state baseline data to assess existing provider capabilities for implementing evidence-based strategies for improved care of CVD. Segment providers.										
Task Step 7: Identify staff needed (e.g. registry coordinator, outreach manager, data manager, pharmacist, care manager, collaborative care nurses) and location (on-site vs. centralized support), roles/responsibilities, local practitioner champions and processes for implementing evidence-based strategies for improving management of CVD. As implementation progresses, modify as needed.										
Task Step 8: Roll out, monitor, and refine rollout of evidence-based strategies for improving management of CVD, as needed.										
Milestone #2 Ensure that all PPS safety net providers are actively connected to EHR systems with local health information										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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/RHIO/SHIN-NY and share health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up, by the end of DY 3.										
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	40	99	198
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	3	7	14
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	0	0	0	0	0	0	0	0	1	2
Task PPS uses alerts and secure messaging functionality.										
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.										
Task Step 3: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business Operations & Information Technology Subcommittee and approval by Executive Committee.										
Task Step 4: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.										
Task Step 5: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.										
Task Step 6: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.										
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.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 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	101	253	505
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.										
Task Step 3: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.										
Task Step 4: Develop target completion dates for each provider to obtain a certified EHR system.										
Task Step 5: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners. Refine as needed.										
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 Step 1: Determine IT infrastructure needed to support patient identification and tracking.										
Task Step 2: Develop plan to create/update patient registries to support patient identification and outreach for those with CVD conditions. Develop data reporting plan to assess data completeness of relevant EHR fields.										
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
support patient identification and tracking.										
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 Step 1: Determine IT infrastructure needed to support patient identification, patient tracking, and provider prompts that facilitate tobacco control protocols, including capacity for periodic self-audits.										
Task Step 2: Develop plan to deploy patient registries and training requirements to support patient identification, patient tracking, and provider prompts.										
Task Step 3: Complete deployment of patient registries to support patient identification, patient tracking, and provider prompts.										
Task Step 4: Define PPS training needs on the use of EHRs in tobacco control protocols, develop training curriculum, and write training materials.										
Task Step 5: Create training curriculum and create training plan.										
Task Step 6: Launch and roll out training program on the use of EHRs in tobacco control protocols.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for adopting standardized treatment protocols for hypertension and elevated cholesterol that align with national guidelines.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Synthesize adoption guidelines and treatment protocols, and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on adoption guidelines and treatment protocols.										
Task Step 4: Refine adoption guidelines and treatment protocols through Hub-based planning process.										
Task Step 5: Identify roles, responsibilities, and processes for providing standardized treatment protocols for hypertension and elevated cholesterol.										
Task Step 6: Establish contracts with partners to follow standardized treatment protocols for hypertension and elevated cholesterol.										
Task Step 7: Create training curriculum and training plan, and roll out training program.										
Task Step 8: Monitor roll out of treatment protocols and refine as needed.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide protocols, procedures and workflows for care coordination teams to address lifestyle changes, medication adherence, health literacy issues, and patient self-management.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Synthesize care coordination clinical protocols and workflows and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on care coordination protocols and workflows.										
Task Step 4: Refine care coordination guidelines through Hub-based planning process.										
Task Step 5: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand partner capacity for coordinating care with other PPS partners to help patients manage lifestyle changes, adhere to medication as prescribed, and self-manage their care. Educate partners on PRAT and roll out PRAT.										
Task Step 6: Analyze current state baseline data to assess existing provider capabilities to coordinate care with other providers. Segment providers.										
Task Step 7: Identify staffing needs, roles, responsibilities, and processes of delivering coordinated care.										
Task Step 8: Contract with partners as needed.										
Task Step 9: Create training curriculum and training plan, and roll out training program										
Task Step 10: Roll out care coordination teams, monitor performance, and refine as needed.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on care coordination protocols.										
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	0	0	0	0	0	101	253	505

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Assess existing provider capabilities to provide follow-up blood pressure checks without a copayment or advanced appointment.										
Task Step 2: Define process to provide follow-up blood pressure checks without a copayment or advanced appointment.										
Task Step 3: Define PPS training needs on process to provide follow-up blood pressure checks without a copayment or advanced appointment.										
Task Step 4: Develop curriculum for training on process to provide follow-up blood pressure checks without a copayment or advanced appointment.										
Task Step 5: Launch and roll-out training program.										
Task Step 6: Monitor roll out and refine process as needed.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide protocol on blood pressure measuring and recording.										
Task Step 2: Synthesize guidelines on blood pressure measuring and recording and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Refine guidelines for measuring and recording blood pressure through Hub-based planning process.										
Task Step 4: Roll out training and monitor process for measuring and recording blood pressure monitoring. Refine as needed.										
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.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY1,Q1	DY1,Q2	DY1,Q3	DY1,Q4	DY2,Q1	DY2,Q2	DY2,Q3	DY2,Q4	DY3,Q1	DY3,Q2
Task PPS uses a patient stratification system to identify patients who have repeated elevated blood pressure but no diagnosis of hypertension.										
Task PPS has implemented an automated scheduling system to facilitate scheduling of targeted hypertension patients.										
Task PPS provides periodic training to staff to ensure effective patient identification and hypertension visit scheduling.										
Task Step 1: Determine IT infrastructure needed to identify patients seen routinely with repeated elevated blood pressures in the medical record but no diagnosis.										
Task Step 2: Determine clinical review process and care team roles in identifying patients needing outreach and scheduling follow up BP visit.										
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification, tracking, and automated scheduling of follow-up visits. Plan should include training requirements.										
Task Step 4: Develop a training program, roll out training program, and track those trained on identification of patients with undiagnosed hypertension.										
Task Step 5: Complete deployment of CCMS and related registries to support patient identification, tracking, and automated scheduling of follow-up visits.										
Task Step 6: Roll out, monitor and refine protocol for identifying those at-risk of HTN and use of CCMS as needed.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide medication algorithm based on ease of medication adherence, efficacy, ease of titration, managed care plan formularies, and										

New York City Health and Hospitals Corporation (PPS ID:52)

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
other relevant criteria.										
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on medication algorithm based on ease of medication adherence.										
Task Step 4: Refine medication algorithm based on ease of medication adherence through Hub-based planning process.										
Task Step 5: Assess current-state Medicaid Managed Care Organizations (MCO) pharmacy benefits as they relate to medication algorithm.										
Task Step 6: Identify opportunities to collaborate with MCOs on pharmacy benefits that will support implementation of medication algorithm.										
Task Step 7: Roll out, monitor implementation of medication algorithm and refine as needed.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for documenting self-management goals in medical records.										
Task Step 2: Synthesize guidelines and IT requirements for documenting self-management goals in medical records and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for documenting self-										

New York City Health and Hospitals Corporation (PPS ID:52)

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
management goals in medical records.										
Task Step 4: Refine guidelines for documenting self-management goals in medical records through Hub-based planning process.										
Task Step 5: Define PPS training needs, for documenting self-management goals through person-centered methods.										
Task Step 6: Develop curriculum for training on person-centered methods that include documenting self-management goals; identify training resources and create training plan.										
Task Step 7: Launch and roll out training program.										
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 Step 1: Through Hub-based planning process, identify and implement agreements with community-based resources to refer patients to and distribute resource lists.										
Task Step 2: Define PPS training needs for making warm referrals and the follow-up process.										
Task Step 3: Develop curriculum for training on making warm referrals and the follow-up process.										
Task Step 4: Identify training resources and create training plan.										
Task Step 5: Launch and roll out training program.										
Task Step 6: Monitor and track referrals, follow-ups, documentation, and feedback, and refine process as needed.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 #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 Step 1: Convene Clinical Leadership Team to define PPS-wide clinical protocol and workflow for home blood pressure monitoring and follow-up support.										
Task Step 2: Synthesize clinical protocol and workflow for home blood pressure monitoring and follow-up support, and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on clinical protocols and workflow for home blood pressure monitoring and follow-up support.										
Task Step 4: Through Hub-based planning process, refine guidelines for home blood pressure monitoring and follow-up support.										
Task Step 5: Identify team capacity and roles, identify equipment vendor, create plan for equipment supply distribution and tracking, determine IT needs for patient tracking.										
Task Step 6: Define PPS training needs for making warm referrals and following up on referrals.										
Task Step 7: Develop curriculum for training on making warm referrals and the follow-up process.										
Task Step 8: Identify training resources, create training plan, launch training program.										
Task Step 9: Monitor referrals, follow-ups, and documentation; refine protocol as needed.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 #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 Step 1: Through Hub-based planning process, refine guidelines for identifying and reaching patients with hypertension.										
Task Step 2: Determine IT infrastructure/registry and reporting needed to identify patients with hypertension and automatically scheduling follow-up appointments.										
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification, tracking, and automated scheduling of follow-up visits. Plan should include training requirements.										
Task Step 4: Complete deployment of CCMS and related registries to support patient identification, tracking, and automated scheduling of follow-up visits.										
Task Step 5: Monitor and refine protocol for identifying and reaching patients with hypertension, and use of CCMS as needed.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task PPS has developed referral and follow-up process and adheres to process.										
Task Step 1: Convene Clinical Leadership Team to define guidelines for referring smokers to the Quitline.										
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for referring smokers to the Quitline.										
Task Step 4: Refine guidelines for referring smokers to the Quitline through Hub-based planning process.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Define PPS training needs on guidelines for referring smokers to the Quitline.										
Task Step 6: Develop curriculum for training on guidelines for referring smokers to the Quitline.										
Task Step 7: Launch and roll-out training program.										
Task Step 8: Monitor roll out and refine process as needed.										
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 Step 1: Based on Community Needs Assessment (CNA) and Medicaid Claims and Encounter data (from SIM tool), identify high risk neighborhoods where PPS may deploy "hot spotting" strategies for high risk populations.										
Task Step 2: Use Partner Readiness Assessment Tool (PRAT) to understand provider capacity to perform additional actions towards the better care management for high risk populations in "hot spot" areas.										
Task Step 3: Analyze current state baseline data to assess existing provider capabilities connecting patients to Health Homes, facilitating group visits, implementing the Stanford Model for chronic diseases, and other additional care strategies that benefit high risk populations. Segment providers.										
Task Step 4: Identify needs, roles, responsibilities, and processes for performance of additional care activities that benefit high-risk										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
populations.										
Task Step 5: Based on provider assessment and "hot spotting" work, contract with partners as necessary.										
Task Step 6: Determine IT infrastructure needed to support patient identification and tracking.										
Task Step 7: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.										
Task Step 8: Complete deployment of CCMS and related registries to support patient identification and tracking.										
Milestone #18 Adopt strategies from the Million Hearts Campaign.										
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	253	505	1,010	1,010	1,010
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	25	49	98	98	98
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	0	0	0	0	0	3	6	11	11	11
Task Step 1: Convene Clinical Leadership Team to define guidelines for adopting strategies from the Million Hearts Campaign.										
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for adopting strategies from the Million Hearts Campaign.										
Task Step 4: Refine guidelines for adopting strategies from the Million Hearts Campaign through Hub-based planning process.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Define PPS training needs on guidelines related to strategies from the Million Hearts Campaign.										
Task Step 6: Develop curriculum for training on guidelines related to strategies from the Million Hearts Campaign.										
Task Step 7: Launch and roll-out training program.										
Task Step 8: Monitor implementation of policies and procedures that reflect principles and initiatives of the Million Hearts Campaign. Refine as needed.										
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 Step 1: Review existing MCO contracts to determine gaps in coverage related to coordination of services for high risk populations.										
Task Step 2: Develop agreements to address coverage gaps.										
Task Step 3: Finalize agreements with MCO partners.										
Milestone #20 Engage a majority (at least 80%) of primary care providers in this project.										
Task PPS has engaged at least 80% of their PCPs in this activity.	0	0	0	0	0	253	505	1,010	1,010	1,010
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand partner capacity to delivery primary care to affected populations. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess the number of primary care providers within a PPS. Segment providers.										
Task										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 3: Identify roles, responsibilities, and processes for engaging primary care providers.										
Task Step 4: Contract with primary care providers as needed.										
Task Step 5: Roll out campaign to engage primary care providers. Monitor number of PCPs in the PPS and revise campaign as needed.										

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 Step 1: Convene Clinical Leadership Team to define PPS-wide programs for improving management of cardiovascular disease (CVD) using evidence-based strategies in ambulatory and community care settings.										
Task Step 2: Synthesize programs for improving management of CVD and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on programs for improving management of CVD.										
Task Step 4: Refine programs for improving management of CVD through Hub-based planning process.										
Task Step 5: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand PPS capacity for implementing evidence-based strategies for improved care of CVD. Educate partners on PRAT and roll out PRAT.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 6: Analyze current state baseline data to assess existing provider capabilities for implementing evidence-based strategies for improved care of CVD. Segment providers.										
Task Step 7: Identify staff needed (e.g. registry coordinator, outreach manager, data manager, pharmacist, care manager, collaborative care nurses) and location (on-site vs. centralized support), roles/responsibilities, local practitioner champions and processes for implementing evidence-based strategies for improving management of CVD. As implementation progresses, modify as needed.										
Task Step 8: Roll out, monitor, and refine rollout of evidence-based strategies for improving management of CVD, as needed.										
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.	296	395	395	395	395	395	395	395	395	395
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	21	28	28	28	28	28	28	28	28	28
Task EHR meets connectivity to RHIO's HIE and SHIN-NY requirements.	3	4	4	4	4	4	4	4	4	4
Task PPS uses alerts and secure messaging functionality.										
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners are not already actively sharing EHR systems with local health information exchange and among clinical partners.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not sufficiently capable for data sharing with local HIE/RHIO/SHIN-NY.										
Task Step 3: Document clinical connectivity roadmap and PPS partner strategy for exchanging clinical data set; review by Business										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Operations & Information Technology Subcommittee and approval by Executive Committee.										
Task Step 4: Develop governance and oversight processes for ensuring partner compliance with connectivity and data sharing requirements.										
Task Step 5: Establish and communicate connectivity priorities, and support resources for partners, including training plans and/or third party assistance programs.										
Task Step 6: Develop approach for tracking and reporting on changes to data sharing agreements. Refine as needed.										
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.	758	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010
Task Step 1: Collect and organize partner IT readiness assessment data to determine which partners have a meaningful use certified EHR system, which partners do not have a certified EHR, or which partners need to move from a non CCHIT EHR.										
Task Step 2: Identify cost-effective options to support clinical partners who do not currently have a meaningful use certified EHR, or whose current EHR is not officially certified to be used in a meaningful manner.										
Task Step 3: Identify cost-effective approaches to oversee implementation and training for PPS partners pursuing an EHR transition.										
Task Step 4: Develop target completion dates for each provider to obtain a certified EHR system.										
Task Step 5: Establish reporting process to track progress of third party resource in overseeing implementation and training with relevant PPS partners. Refine as needed.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 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 Step 1: Determine IT infrastructure needed to support patient identification and tracking.										
Task Step 2: Develop plan to create/update patient registries to support patient identification and outreach for those with CVD conditions. Develop data reporting plan to assess data completeness of relevant EHR fields.										
Task Step 3: Complete deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification and tracking.										
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 Step 1: Determine IT infrastructure needed to support patient identification, patient tracking, and provider prompts that facilitate tobacco control protocols, including capacity for periodic self-audits.										
Task Step 2: Develop plan to deploy patient registries and training requirements to support patient identification, patient tracking, and provider prompts.										
Task Step 3: Complete deployment of patient registries to support patient identification, patient tracking, and provider prompts.										
Task Step 4: Define PPS training needs on the use of EHRs in tobacco control protocols, develop training curriculum, and write training materials.										
Task Step 5: Create training curriculum and create training plan.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 6: Launch and roll out training program on the use of EHRs in tobacco control protocols.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for adopting standardized treatment protocols for hypertension and elevated cholesterol that align with national guidelines.										
Task Step 2: Synthesize adoption guidelines and treatment protocols, and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on adoption guidelines and treatment protocols.										
Task Step 4: Refine adoption guidelines and treatment protocols through Hub-based planning process.										
Task Step 5: Identify roles, responsibilities, and processes for providing standardized treatment protocols for hypertension and elevated cholesterol.										
Task Step 6: Establish contracts with partners to follow standardized treatment protocols for hypertension and elevated cholesterol.										
Task Step 7: Create training curriculum and training plan, and roll out training program.										
Task Step 8: Monitor roll out of treatment protocols and refine as needed.										
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,										

New York City Health and Hospitals Corporation (PPS ID:52)

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 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 Step 1: Convene Clinical Leadership Team to define PPS-wide protocols, procedures and workflows for care coordination teams to address lifestyle changes, medication adherence, health literacy issues, and patient self-management.										
Task Step 2: Synthesize care coordination clinical protocols and workflows and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on care coordination protocols and workflows.										
Task Step 4: Refine care coordination guidelines through Hub-based planning process.										
Task Step 5: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand partner capacity for coordinating care with other PPS partners to help patients manage lifestyle changes, adhere to medication as prescribed, and self-manage their care. Educate partners on PRAT and roll out PRAT.										
Task Step 6: Analyze current state baseline data to assess existing provider capabilities to coordinate care with other providers. Segment providers.										
Task Step 7: Identify staffing needs, roles, responsibilities, and processes of delivering coordinated care.										
Task Step 8: Contract with partners as needed.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 9: Create training curriculum and training plan, and roll out training program										
Task Step 10: Roll out care coordination teams, monitor performance, and refine as needed.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on care coordination protocols.										
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.	758	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010
Task Step 1: Assess existing provider capabilities to provide follow-up blood pressure checks without a copayment or advanced appointment.										
Task Step 2: Define process to provide follow-up blood pressure checks without a copayment or advanced appointment.										
Task Step 3: Define PPS training needs on process to provide follow-up blood pressure checks without a copayment or advanced appointment.										
Task Step 4: Develop curriculum for training on process to provide follow-up blood pressure checks without a copayment or advanced appointment.										
Task Step 5: Launch and roll-out training program.										
Task Step 6: Monitor roll out and refine process as needed.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide protocol on blood pressure measuring and recording.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Synthesize guidelines on blood pressure measuring and recording and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Refine guidelines for measuring and recording blood pressure through Hub-based planning process.										
Task Step 4: Roll out training and monitor process for measuring and recording blood pressure monitoring. Refine as needed.										
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 Step 1: Determine IT infrastructure needed to identify patients seen routinely with repeated elevated blood pressures in the medical record but no diagnosis.										
Task Step 2: Determine clinical review process and care team roles in identifying patients needing outreach and scheduling follow up BP visit.										
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification, tracking, and automated scheduling of follow-up visits. Plan should include training requirements.										
Task Step 4: Develop a training program, roll out training program, and track those trained on identification of patients with undiagnosed hypertension.										
Task Step 5: Complete deployment of CCMS and related registries to support patient identification, tracking, and automated scheduling										

New York City Health and Hospitals Corporation (PPS ID:52)

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 follow-up visits.										
Task Step 6: Roll out, monitor and refine protocol for identifying those at-risk of HTN and use of CCMS as needed.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide medication algorithm based on ease of medication adherence, efficacy, ease of titration, managed care plan formularies, and other relevant criteria.										
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on medication algorithm based on ease of medication adherence.										
Task Step 4: Refine medication algorithm based on ease of medication adherence through Hub-based planning process.										
Task Step 5: Assess current-state Medicaid Managed Care Organizations (MCO) pharmacy benefits as they relate to medication algorithm.										
Task Step 6: Identify opportunities to collaborate with MCOs on pharmacy benefits that will support implementation of medication algorithm.										
Task Step 7: Roll out, monitor implementation of medication algorithm and refine as needed.										
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.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 provides periodic training to staff on person-centered methods that include documentation of self-management goals.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for documenting self-management goals in medical records.										
Task Step 2: Synthesize guidelines and IT requirements for documenting self-management goals in medical records and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for documenting self-management goals in medical records.										
Task Step 4: Refine guidelines for documenting self-management goals in medical records through Hub-based planning process.										
Task Step 5: Define PPS training needs, for documenting self-management goals through person-centered methods.										
Task Step 6: Develop curriculum for training on person-centered methods that include documenting self-management goals; identify training resources and create training plan.										
Task Step 7: Launch and roll out training program.										
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 Step 1: Through Hub-based planning process, identify and										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
implement agreements with community-based resources to refer patients to and distribute resource lists.										
Task Step 2: Define PPS training needs for making warm referrals and the follow-up process.										
Task Step 3: Develop curriculum for training on making warm referrals and the follow-up process.										
Task Step 4: Identify training resources and create training plan.										
Task Step 5: Launch and roll out training program.										
Task Step 6: Monitor and track referrals, follow-ups, documentation, and feedback, and refine process as needed.										
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 Step 1: Convene Clinical Leadership Team to define PPS-wide clinical protocol and workflow for home blood pressure monitoring and follow-up support.										
Task Step 2: Synthesize clinical protocol and workflow for home blood pressure monitoring and follow-up support, and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on clinical protocols and workflow for home blood pressure monitoring and follow-up support.										
Task Step 4: Through Hub-based planning process, refine guidelines for home blood pressure monitoring and follow-up support.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Identify team capacity and roles, identify equipment vendor, create plan for equipment supply distribution and tracking, determine IT needs for patient tracking.										
Task Step 6: Define PPS training needs for making warm referrals and following up on referrals.										
Task Step 7: Develop curriculum for training on making warm referrals and the follow-up process.										
Task Step 8: Identify training resources, create training plan, launch training program.										
Task Step 9: Monitor referrals, follow-ups, and documentation; refine protocol as needed.										
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 Step 1: Through Hub-based planning process, refine guidelines for identifying and reaching patients with hypertension.										
Task Step 2: Determine IT infrastructure/registry and reporting needed to identify patients with hypertension and automatically scheduling follow-up appointments.										
Task Step 3: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification, tracking, and automated scheduling of follow-up visits. Plan should include training requirements.										
Task Step 4: Complete deployment of CCMS and related registries to support patient identification, tracking, and automated scheduling of follow-up visits.										
Task Step 5: Monitor and refine protocol for identifying and reaching patients with hypertension, and use of CCMS as needed.										
Milestone #16 Facilitate referrals to NYS Smoker's Quitline.										
Task										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
PPS has developed referral and follow-up process and adheres to process.										
Task Step 1: Convene Clinical Leadership Team to define guidelines for referring smokers to the Quitline.										
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for referring smokers to the Quitline.										
Task Step 4: Refine guidelines for referring smokers to the Quitline through Hub-based planning process.										
Task Step 5: Define PPS training needs on guidelines for referring smokers to the Quitline.										
Task Step 6: Develop curriculum for training on guidelines for referring smokers to the Quitline.										
Task Step 7: Launch and roll-out training program.										
Task Step 8: Monitor roll out and refine process as needed.										
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 Step 1: Based on Community Needs Assessment (CNA) and										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Medicaid Claims and Encounter data (from SIM tool), identify high risk neighborhoods where PPS may deploy "hot spotting" strategies for high risk populations.										
Task Step 2: Use Partner Readiness Assessment Tool (PRAT) to understand provider capacity to perform additional actions towards the better care management for high risk populations in "hot spot" areas.										
Task Step 3: Analyze current state baseline data to assess existing provider capabilities connecting patients to Health Homes, facilitating group visits, implementing the Stanford Model for chronic diseases, and other additional care strategies that benefit high risk populations. Segment providers.										
Task Step 4: Identify needs, roles, responsibilities, and processes for performance of additional care activities that benefit high-risk populations.										
Task Step 5: Based on provider assessment and "hot spotting" work, contract with partners as necessary.										
Task Step 6: Determine IT infrastructure needed to support patient identification and tracking.										
Task Step 7: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries, to support patient identification and tracking, including training requirements.										
Task Step 8: Complete deployment of CCMS and related registries to support patient identification and tracking.										
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.	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million Hearts Campaign.	98	98	98	98	98	98	98	98	98	98
Task Provider can demonstrate implementation of policies and procedures which reflect principles and initiatives of Million	11	11	11	11	11	11	11	11	11	11

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Hearts Campaign.										
Task Step 1: Convene Clinical Leadership Team to define guidelines for adopting strategies from the Million Hearts Campaign.										
Task Step 2: Obtain input from PAC on guidelines. PAC is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for adopting strategies from the Million Hearts Campaign.										
Task Step 4: Refine guidelines for adopting strategies from the Million Hearts Campaign through Hub-based planning process.										
Task Step 5: Define PPS training needs on guidelines related to strategies from the Million Hearts Campaign.										
Task Step 6: Develop curriculum for training on guidelines related to strategies from the Million Hearts Campaign.										
Task Step 7: Launch and roll-out training program.										
Task Step 8: Monitor implementation of policies and procedures that reflect principles and initiatives of the Million Hearts Campaign. Refine as needed.										
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 Step 1: Review existing MCO contracts to determine gaps in coverage related to coordination of services for high risk populations.										
Task Step 2: Develop agreements to address coverage gaps.										
Task Step 3: Finalize agreements with MCO partners.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 #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.	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010	1,010
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand partner capacity to delivery primary care to affected populations. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess the number of primary care providers within a PPS. Segment providers.										
Task Step 3: Identify roles, responsibilities, and processes for engaging primary care providers.										
Task Step 4: Contract with primary care providers as needed.										
Task Step 5: Roll out campaign to engage primary care providers. Monitor number of PCPs in the PPS and revise campaign as needed.										

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.	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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.	The newly uploaded step 3 will replace the 'On Hold' step 3 to clarify that the Care Models Committee's focus will be on clinical protocols. However, detailed workflows will be developed via operational planning with specific partners.
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.	
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.	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
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	
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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone Review Status

Milestone #	Review Status	IA Formal Comments
Milestone #19	Pass & Ongoing	
Milestone #20	Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 3.d.ii – Expansion of asthma home-based self-management program

IPQR Module 3.d.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.

We have identified several risks to this project. The first is the capacity to provide a comprehensive home-based intervention. As we described in our application, there are a number of existing resources, such as NYC's Healthy Homes program or a.i.r. NYC, to support implementation of this program. Given that a number of other PPSs have selected the asthma-home based project, we are concerned that these resources will not be sufficient to meet the needs of the attributed population. To mitigate this risk, we have identified several strategies. First, we are assessing the capacity of our partners to determine where additional capacity may exist. Second, we are identifying opportunities to support partners to develop capacity. Third, we intend to develop a strategy to recruit and train community health workers. Finally, we are coordinating implementation with other PPSs where feasible to establish community resources to do integrated pest management to reduce environmental triggers.

We also anticipate risks associated with the challenge of patient retention in home-based programs. To mitigate this risk our PPS is considering whether to make available patient incentives related to trigger remediation (e.g., pillow cases) in order to improve retention.

The final risk we have identified relates to health IT. While this intervention is primarily home-based and can leverage the use of non-clinical workers, there is also a need to connect with the emergency department (ED) so that when patients are discharged, a root cause analysis of the ED admission can be performed. Connectivity with primary care will also be important in order to support patients in following their asthma action plan, among other activities. We are concerned that the current degree of connectivity – particularly among some of our community-based partners, -- may not sufficiently support data sharing as needed to be effective. To mitigate this risk we have begun to assess partner health IT capabilities and we have established a set of IT requirements related to all DSRIP projects. Once we have completed a detailed landscape assessment, we will develop an approach to deploying IT and providing implementation and training support to address partner needs in order of priority.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.d.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	11,685

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
0	0	0.00%	584	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (584)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
nholder9	Baseline or Performance Documentation	52_PMDL4715_1_3_20160125142553_OneCity_Health_Patient_Engagement_Commitments.pdf	Please see page 7 with the patient engagement speed commitments for this project, which begin in DY1 Q4.	01/25/2016 02:26 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.d.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 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Develop Asthma Baseline / Readiness Assessment Survey to identify available community medical and social service providers within the geographic areas, and understand PPS capacity for assessing patients' homes and educating patients on self-management of asthma. Educate partners and roll out survey.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Use Community Needs Assessment (CNA) data and other data sources to target areas of highest need for asthma home-based self-management program.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Develop an Asthma Task Force in collaboration and partnership with community's medical, social and other services providers. The Task Force will develop and update strategies for implementation, monitoring and evaluation on an ongoing basis/as needed.	Project		In Progress	07/01/2015	12/31/2016	07/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Identify/develop evidence-based best practice protocols/standards for patient's home environmental assessment and home-based patient asthma self-management.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 5: Develop / update contracts with partners to provide patient home environmental assessments, to identify asthma triggers. Develop / update contracts with partners to provide patient home environmental interventions, to remediate those environmental triggers.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 6: Define PPS training needs for protocols on patient self-management and protocols for clinical providers and health educators / CHW / Care Managers. Develop curriculum for training. Identify training resources, create training plan, and launch training plan. Coordinate with collaborating PPSs, as appropriate.	Project		In Progress	10/01/2015	12/31/2016	10/01/2015	12/31/2016	12/31/2016	DY2 Q3
Task Step 7: Pilot home visits and follow-ups. Monitor performance, including rosters of patients who have received home-based interventions. Refine and roll out program across PPS.	Project		In Progress	01/01/2016	03/31/2018	01/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: The Asthma Task Force will convene a Clinical Leadership Team to define PPS-wide guidelines for evidence-based trigger reduction interventions. These interventions would target specifically indoor environmental management of asthma. The team will be represented with participants from multidisciplinary areas of expertise (e.g., physicians, nurses, health educators, community health workers, healthy homes, pest management, smoking counselors, social workers, legal services, NYC-DOHMH, NYCHA).	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task	Project		Completed	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
Step 2: Synthesize intervention guidelines and obtain input from the baseline/readiness survey.									
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on intervention guidelines, including process and workflow, to monitor proper implementation and compliance with the guidelines for connecting clients to resources for trigger reduction interventions.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 4: Refine intervention guidelines through Hub-based planning process and Asthma Task Force committee meetings.	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Define and monitor PPS-wide and hub-based training needs for intervention program, including providers and CBOs.	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 6: Identify/Develop evidence-based, best practice education and training materials for intervention protocols for indoor trigger reductions.	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Launch and roll out training program.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop and implement evidence-based asthma management guidelines.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for evidence-based asthma management.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize asthma management guidelines and obtain input from the baseline/readiness survey. Coordinate with collaborating PPSs, as appropriate.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on asthma management guidelines.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Refine asthma management guidelines through Hub-	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
based planning process and Asthma Task Force committee meetings.									
Task Step 5: Monitor application of management guidelines. Periodically evaluate and revise as needed.	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Project	N/A	In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Define PPS patients' training needs for self-management including environmental assessment and self-monitoring.	Project		In Progress	04/01/2016	09/30/2016	04/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Identify/Develop curriculum for training and education in asthma self-management.	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Identify/Develop training resources (including online-web based) and create training plans that include patient outreach incentives, patient education materials, and patient self-monitoring tools.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Incorporate plan and materials into a pilot project before broader rollout.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Monitor training program, including the number of patients trained in both one-on-one sessions and in group sessions.	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 has developed and conducted training of all providers, including social services and support.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task Step 1: Determine IT infrastructure needed to support asthma patient identification and tracking and asthma care coordination.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification, tracking, and coordination.	Project		In Progress	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Identify care teams that include nursing staff, pharmacists, dieticians, community health workers, and social service providers and develop care coordination workflows as part of hub-based planning process.	Project		In Progress	07/01/2015	03/31/2016	07/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Define care team training needs for delivering coordinated care to the PPS's asthma patients and for using CCMS and related registries.	Project		In Progress	04/01/2016	06/30/2016	04/01/2016	06/30/2016	06/30/2016	DY2 Q1
Task Step 5: Develop curriculum for training care teams in coordinated care of asthma patients and the use of CCMS and related registries; identify training resources and create training plans.	Project		In Progress	07/01/2016	09/30/2016	07/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Launch and roll out asthma coordinated care training program.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 7: Complete deployment of CCMS and related registries to support asthma patient identification and tracking.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 8: Monitor application of coordinated care guidelines and refine as needed.	Project		In Progress	04/01/2017	03/31/2018	04/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for periodic follow-up services and for root cause analysis methodology for patients discharge from the ED and inpatient units.	Project		In Progress	04/01/2015	09/30/2016	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Synthesize guidelines for periodic follow-up services and for root cause analysis and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on follow-up guidelines.	Project		In Progress	10/01/2016	12/31/2016	10/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 4: Refine follow-up guidelines through Hub-based planning process and Asthma Task Force committee meetings.	Project		In Progress	01/01/2017	03/31/2017	01/01/2017	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine IT infrastructure needed to support patient identification and tracking.	Project		In Progress	07/01/2015	06/30/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.	Project		In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to assess PPS's level of coordination with Medicaid Managed Care plans, Health Home care managers, PCPs, and specialty providers.	Project		Completed	04/01/2015	06/30/2015	04/01/2015	06/30/2015	06/30/2015	DY1 Q1
Task Step 2: Analyze current state baseline data to assess existing clinical provider capabilities in the treatment of asthma patients. Segment providers. Review current national and state baseline data to identify existing community programs and their scope of services.	Project		Completed	07/01/2015	12/31/2015	07/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes along the continuum of care for asthma patients and any coverage-related gaps.	Project		In Progress	01/01/2016	03/31/2016	01/01/2016	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Establish contracts with partners that address services for patients with asthma and related health issues.	Project		In Progress	04/01/2016	12/31/2016	04/01/2016	12/31/2016	12/31/2016	DY2 Q3
Task Step 5: Establish agreements with MCOs that address coverage of patients with asthma health issues.	Project		In Progress	01/01/2017	03/31/2018	01/01/2017	03/31/2018	03/31/2018	DY3 Q4
Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll out training program on interim tracking	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
process.									
Task Step 4: Monitor implementation of interim tracking process and refine as needed.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Develop CCMS training requirements.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	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 Expand asthma home-based self-management program to										

New York City Health and Hospitals Corporation (PPS ID:52)

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 home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.										
Task Step 1: Develop Asthma Baseline / Readiness Assessment Survey to identify available community medical and social service providers within the geographic areas, and understand PPS capacity for assessing patients' homes and educating patients on self-management of asthma. Educate partners and roll out survey.										
Task Step 2: Use Community Needs Assessment (CNA) data and other data sources to target areas of highest need for asthma home-based self-management program.										
Task Step 3: Develop an Asthma Task Force in collaboration and partnership with community's medical, social and other services providers. The Task Force will develop and update strategies for implementation, monitoring and evaluation on an ongoing basis/as needed.										
Task Step 4: Identify/develop evidence-based best practice protocols/standards for patient's home environmental assessment and home-based patient asthma self-management.										
Task Step 5: Develop / update contracts with partners to provide patient home environmental assessments, to identify asthma triggers. Develop / update contracts with partners to provide patient home environmental interventions, to remediate those environmental triggers.										
Task Step 6: Define PPS training needs for protocols on patient self-management and protocols for clinical providers and health educators / CHW / Care Managers. Develop curriculum for training. Identify training resources, create training plan, and launch training plan. Coordinate with collaborating PPSs, as appropriate.										
Task Step 7: Pilot home visits and follow-ups. Monitor performance, including rosters of patients who have received home-based interventions. Refine and roll out program across PPS.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.										
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										
Task Step 1: The Asthma Task Force will convene a Clinical Leadership Team to define PPS-wide guidelines for evidence-based trigger reduction interventions. These interventions would target specifically indoor environmental management of asthma. The team will be represented with participants from multidisciplinary areas of expertise (e.g., physicians, nurses, health educators, community health workers, healthy homes, pest management, smoking counselors, social workers, legal services, NYC-DOHMH, NYCHA).										
Task Step 2: Synthesize intervention guidelines and obtain input from the baseline/readiness survey.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on intervention guidelines, including process and workflow, to monitor proper implementation and compliance with the guidelines for connecting clients to resources for trigger reduction interventions.										
Task Step 4: Refine intervention guidelines through Hub-based planning process and Asthma Task Force committee meetings.										
Task Step 5: Define and monitor PPS-wide and hub-based training needs for intervention program, including providers and CBOs.										
Task Step 6: Identify/Develop evidence-based, best practice education and training materials for intervention protocols for indoor trigger reductions.										
Task Step 7: Launch and roll out training program.										
Milestone #3 Develop and implement evidence-based asthma management guidelines.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for evidence-based asthma management.										
Task Step 2: Synthesize asthma management guidelines and obtain input from the baseline/readiness survey. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on asthma management guidelines.										
Task Step 4: Refine asthma management guidelines through Hub-based planning process and Asthma Task Force committee meetings.										
Task Step 5: Monitor application of management guidelines. Periodically evaluate and revise as needed.										
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task Step 1: Define PPS patients' training needs for self-management including environmental assessment and self-monitoring.										
Task Step 2: Identify/Develop curriculum for training and education in asthma self-management.										
Task Step 3: Identify/Develop training resources (including online-web based) and create training plans that include patient outreach incentives, patient education materials, and patient self-monitoring tools.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Incorporate plan and materials into a pilot project before broader rollout.										
Task Step 5: Monitor training program, including the number of patients trained in both one-on-one sessions and in group sessions.										
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.										
Task PPS has developed and conducted training of all providers, including social services and support.										
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.										
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Step 1: Determine IT infrastructure needed to support asthma patient identification and tracking and asthma care coordination.										
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification, tracking, and coordination.										
Task Step 3: Identify care teams that include nursing staff, pharmacists, dieticians, community health workers, and social service providers and develop care coordination workflows as part of hub-based planning process.										
Task Step 4: Define care team training needs for delivering coordinated care to the PPS's asthma patients and for using CCMS and related registries.										
Task Step 5: Develop curriculum for training care teams in coordinated care of asthma patients and the use of CCMS and related registries; identify training resources and create training plans.										
Task Step 6: Launch and roll out asthma coordinated care training program.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 7: Complete deployment of CCMS and related registries to support asthma patient identification and tracking.										
Task Step 8: Monitor application of coordinated care guidelines and refine as needed.										
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.										
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's family.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for periodic follow-up services and for root cause analysis methodology for patients discharge from the ED and inpatient units.										
Task Step 2: Synthesize guidelines for periodic follow-up services and for root cause analysis and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on follow-up guidelines.										
Task Step 4: Refine follow-up guidelines through Hub-based planning process and Asthma Task Force committee meetings.										
Task Step 5: Determine IT infrastructure needed to support patient identification and tracking.										
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT,										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
operational, and staffing capacity and capabilities. Use PRAT to assess PPS's level of coordination with Medicaid Managed Care plans, Health Home care managers, PCPs, and specialty providers.										
Task Step 2: Analyze current state baseline data to assess existing clinical provider capabilities in the treatment of asthma patients. Segment providers. Review current national and state baseline data to identify existing community programs and their scope of services.										
Task Step 3: Identify roles, responsibilities, and processes along the continuum of care for asthma patients and any coverage-related gaps.										
Task Step 4: Establish contracts with partners that address services for patients with asthma and related health issues.										
Task Step 5: Establish agreements with MCOs that address coverage of patients with asthma health issues.										
Milestone #8 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 Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 3: Launch and roll out training program on interim tracking process.										
Task Step 4: Monitor implementation of interim tracking process and refine as needed.										
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements,										

New York City Health and Hospitals Corporation (PPS ID:52)

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
socialize requirements with key partners.										
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.										
Task Step 9: Develop CCMS training requirements.										
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.										
Task PPS has developed a strategy for the collaboration of community medical and social services providers to assess a patient's home and provide self-management education for the appropriate control of asthma.										
Task Step 1: Develop Asthma Baseline / Readiness Assessment Survey to identify available community medical and social service providers within the geographic areas, and understand PPS capacity for assessing patients' homes and educating patients on self-management of asthma. Educate partners and roll out survey.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 2: Use Community Needs Assessment (CNA) data and other data sources to target areas of highest need for asthma home-based self-management program.										
Task Step 3: Develop an Asthma Task Force in collaboration and partnership with community's medical, social and other services providers. The Task Force will develop and update strategies for implementation, monitoring and evaluation on an ongoing basis/as needed.										
Task Step 4: Identify/develop evidence-based best practice protocols/standards for patient's home environmental assessment and home-based patient asthma self-management.										
Task Step 5: Develop / update contracts with partners to provide patient home environmental assessments, to identify asthma triggers. Develop / update contracts with partners to provide patient home environmental interventions, to remediate those environmental triggers.										
Task Step 6: Define PPS training needs for protocols on patient self-management and protocols for clinical providers and health educators / CHW / Care Managers. Develop curriculum for training. Identify training resources, create training plan, and launch training plan. Coordinate with collaborating PPSs, as appropriate.										
Task Step 7: Pilot home visits and follow-ups. Monitor performance, including rosters of patients who have received home-based interventions. Refine and roll out program across PPS.										
Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.										
Task PPS has developed intervention protocols and identified resources in the community to assist patients with needed evidence-based trigger reduction interventions.										
Task Step 1: The Asthma Task Force will convene a Clinical Leadership Team to define PPS-wide guidelines for evidence-based trigger reduction interventions. These interventions would										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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
target specifically indoor environmental management of asthma. The team will be represented with participants from multidisciplinary areas of expertise (e.g., physicians, nurses, health educators, community health workers, healthy homes, pest management, smoking counselors, social workers, legal services, NYC-DOHMH, NYCHA).										
Task Step 2: Synthesize intervention guidelines and obtain input from the baseline/readiness survey.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on intervention guidelines, including process and workflow, to monitor proper implementation and compliance with the guidelines for connecting clients to resources for trigger reduction interventions.										
Task Step 4: Refine intervention guidelines through Hub-based planning process and Asthma Task Force committee meetings.										
Task Step 5: Define and monitor PPS-wide and hub-based training needs for intervention program, including providers and CBOs.										
Task Step 6: Identify/Develop evidence-based, best practice education and training materials for intervention protocols for indoor trigger reductions.										
Task Step 7: Launch and roll out training program.										
Milestone #3 Develop and implement evidence-based asthma management guidelines.										
Task PPS incorporates evidence-based guidelines that are periodically evaluated and revised, if necessary, in the design and implementation of asthma management.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for evidence-based asthma management.										
Task Step 2: Synthesize asthma management guidelines and obtain input from the baseline/readiness survey. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on asthma management guidelines.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Refine asthma management guidelines through Hub-based planning process and Asthma Task Force committee meetings.										
Task Step 5: Monitor application of management guidelines. Periodically evaluate and revise as needed.										
Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task PPS has developed training and comprehensive asthma self-management education, to include basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.										
Task Step 1: Define PPS patients' training needs for self-management including environmental assessment and self-monitoring.										
Task Step 2: Identify/Develop curriculum for training and education in asthma self-management.										
Task Step 3: Identify/Develop training resources (including online-web based) and create training plans that include patient outreach incentives, patient education materials, and patient self-monitoring tools.										
Task Step 4: Incorporate plan and materials into a pilot project before broader rollout.										
Task Step 5: Monitor training program, including the number of patients trained in both one-on-one sessions and in group sessions.										
Milestone #5 Ensure coordinated care for asthma patients includes social services and support.										
Task PPS has developed and conducted training of all providers, including social services and support.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Task All practices in PPS have a Clinical Interoperability System in place for all participating providers.										
Task PPS has assembled a care coordination team that includes use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.										
Task Step 1: Determine IT infrastructure needed to support asthma patient identification and tracking and asthma care coordination.										
Task Step 2: Develop plan to deploy Centralized Care Coordination and Management Solution (CCMS) and related registries to support patient identification, tracking, and coordination.										
Task Step 3: Identify care teams that include nursing staff, pharmacists, dieticians, community health workers, and social service providers and develop care coordination workflows as part of hub-based planning process.										
Task Step 4: Define care team training needs for delivering coordinated care to the PPS's asthma patients and for using CCMS and related registries.										
Task Step 5: Develop curriculum for training care teams in coordinated care of asthma patients and the use of CCMS and related registries; identify training resources and create training plans.										
Task Step 6: Launch and roll out asthma coordinated care training program.										
Task Step 7: Complete deployment of CCMS and related registries to support asthma patient identification and tracking.										
Task Step 8: Monitor application of coordinated care guidelines and refine as needed.										
Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.										
Task Follow-up services implemented after ED or hospital visit occurs. Root cause analysis is conducted and shared with patient's										

New York City Health and Hospitals Corporation (PPS ID:52)

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
family.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for periodic follow-up services and for root cause analysis methodology for patients discharge from the ED and inpatient units.										
Task Step 2: Synthesize guidelines for periodic follow-up services and for root cause analysis and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on follow-up guidelines.										
Task Step 4: Refine follow-up guidelines through Hub-based planning process and Asthma Task Force committee meetings.										
Task Step 5: Determine IT infrastructure needed to support patient identification and tracking.										
Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.										
Task PPS has established agreements with MCOs that address the coverage of patients with asthma health issues. PPS has established agreements with health home care managers, PCPs, and specialty providers.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to assess PPS's level of coordination with Medicaid Managed Care plans, Health Home care managers, PCPs, and specialty providers.										
Task Step 2: Analyze current state baseline data to assess existing clinical provider capabilities in the treatment of asthma patients. Segment providers. Review current national and state baseline data to identify existing community programs and their scope of services.										
Task Step 3: Identify roles, responsibilities, and processes along the										

New York City Health and Hospitals Corporation (PPS ID:52)

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
continuum of care for asthma patients and any coverage-related gaps.										
Task Step 4: Establish contracts with partners that address services for patients with asthma and related health issues.										
Task Step 5: Establish agreements with MCOs that address coverage of patients with asthma health issues.										
Milestone #8 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 Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 3: Launch and roll out training program on interim tracking process.										
Task Step 4: Monitor implementation of interim tracking process and refine as needed.										
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on										

New York City Health and Hospitals Corporation (PPS ID:52)

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
software specifications.										
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.										
Task Step 9: Develop CCMS training requirements.										
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										

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
Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	
Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	
Develop and implement evidence-based asthma management guidelines.	
Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	
Ensure coordinated care for asthma patients includes social services and support.	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Prescribed Milestones Narrative Text

Milestone Name	Narrative Text
Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	
Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	
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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.d.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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

Instructions :

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

Our PPS has extensive palliative care resources. For example, each of the 12 hospitals has palliative care experts who serve a broad range of patient needs. In contrast, our PPS is very limited in terms of the palliative care that is provided in a primary care or patient centered medical home (PCMH) setting. The primary risk we anticipate encountering is the ability of very busy primary care practices to integrate generalist palliative care services and education into their practice. This is due to sometimes short patient visits, workflow changes and data collection (e.g., advanced care directives), managing care transitions, and the need to establish new referral patterns. Our PPS will mitigate this risk by providing standardized training and materials to both providers and other members of the care team, as well as making available an enterprise-wide care management platform. In addition, we will explore the possibility of hiring specially trained physician extenders to support patients' palliative care needs.

Another significant risk involves the requirement that project outcomes be measured using the NY UAS tool. For engaged patients not enrolled in a Managed Long Term Care program, this requirement places a significant burden on the PPS to conduct extensive UAS assessments twice per year for the purpose of collecting outcome measures. In order to administer the UAS, a provider must go through ~40 hours of training, and the assessment itself takes several hours to administer. OneCity Health will attempt to mitigate this risk by working with the State and other impacted PPSs to design an alternative solution for outcome metric collection; we will also leverage providers within our network with existing experience and capacity in administering the UAS.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.g.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	19,648

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
0	0	0.00%	491	0.00%

Warning: Please note that your DY1,Q3 Patient update does not meet your committed amount (491)

Current File Uploads

User ID	File Type	File Name	File Description	Upload Date
nholder9	Baseline or Performance Documentation	52_PMDL5115_1_3_20160125155435_OneCity_Health_Patient_Engagement_Commitments.pdf	Please see page 8 with the patient engagement speed commitments for this project, which begin in DY1 Q4.	01/25/2016 03:54 PM

Narrative Text :

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

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 3.g.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 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Project	N/A	In Progress	04/01/2015	03/31/2018	04/01/2015	03/31/2018	03/31/2018	DY3 Q4
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	Provider	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 Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand primary care network PCMH certification status and capacity/readiness for palliative care integration. Educate partners on PRAT and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess existing provider capabilities for implementing evidence-based strategies for integration of palliative care and achieving 2014 Level 1 NCQA PCMH certification. Segment providers.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes for integration of palliative care protocols; sign agreements with identified providers.	Project		In Progress	10/01/2015	03/31/2018	10/01/2015	03/31/2018	03/31/2018	DY3 Q4
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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 into the practice.									
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to identify community and provider resources to bring palliative care supports and services into primary care practices. Educate partners on PRAT and roll out PRAT.	Project		Completed	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Analyze current state baseline data to assess existing provider capabilities provide palliative care supports and services. Segment providers.	Project		Completed	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 3: Identify roles, responsibilities, and processes for community and provider organizations related to the integration of palliative care into the primary care setting.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Contract with partners as needed.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for integration of palliative care protocols into the primary care setting.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Synthesize guidelines for integration of palliative care and obtain input from PAC, which is comprised of all partners	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

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
including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.									
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for palliative care integration.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Refine guidelines for palliative care integration through Hub-based planning process.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 5: Roll out and monitor the implementation of palliative care integration. Revise as needed.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Project	N/A	In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.	Project		In Progress	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Define PPS provider training needs for enhancing competence in palliative care skills and protocols.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Develop curriculum for training and education in palliative care protocols tailored to the primary care setting.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Identify training resources and create training plan.	Project		In Progress	10/01/2015	03/31/2016	10/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 4: Launch and roll-out palliative care training plan	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Monitor training program, including the number of providers trained.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Project	N/A	In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.	Project		In Progress	04/01/2016	03/31/2018	04/01/2016	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Review existing MCO contracts to determine gaps in coverage related to palliative care.	Project		In Progress	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Develop agreements to address coverage gaps.	Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Task Step 3: Finalize agreements with MCO partners.	Project		In Progress	10/01/2016	03/31/2018	10/01/2016	03/31/2018	03/31/2018	DY3 Q4
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Project	N/A	In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.	Project		In Progress	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.	Project		In Progress	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Step 3: Launch and roll out training program on interim tracking process.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 4: Monitor implementation of interim tracking process and refine as needed.	Project		In Progress	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.	Project		In Progress	04/01/2015	12/31/2015	04/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 9: Develop CCMS training requirements.	Project		In Progress	01/01/2016	09/30/2016	01/01/2016	09/30/2016	09/30/2016	DY2 Q2
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.	Project		In Progress	10/01/2016	03/31/2017	10/01/2016	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 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.										
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	0	0	0	0	0	0	0	32	79	158
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand primary care network PCMH certification status and capacity/readiness for palliative care integration. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess existing										

New York City Health and Hospitals Corporation (PPS ID:52)

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
provider capabilities for implementing evidence-based strategies for integration of palliative care and achieving 2014 Level 1 NCQA PCMH certification. Segment providers.										
Task Step 3: Identify roles, responsibilities, and processes for integration of palliative care protocols; sign agreements with identified providers.										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										
Task The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to identify community and provider resources to bring palliative care supports and services into primary care practices. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess existing provider capabilities provide palliative care supports and services. Segment providers.										
Task Step 3: Identify roles, responsibilities, and processes for community and provider organizations related to the integration of palliative care into the primary care setting.										
Task Step 4: Contract with partners as needed.										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for integration of palliative care protocols into the										

New York City Health and Hospitals Corporation (PPS ID:52)

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 setting.										
Task Step 2: Synthesize guidelines for integration of palliative care and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for palliative care integration.										
Task Step 4: Refine guidelines for palliative care integration through Hub-based planning process.										
Task Step 5: Roll out and monitor the implementation of palliative care integration. Revise as needed.										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task Step 1: Define PPS provider training needs for enhancing competence in palliative care skills and protocols.										
Task Step 2: Develop curriculum for training and education in palliative care protocols tailored to the primary care setting.										
Task Step 3: Identify training resources and create training plan.										
Task Step 4: Launch and roll-out palliative care training plan										
Task Step 5: Monitor training program, including the number of providers trained.										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 1: Review existing MCO contracts to determine gaps in coverage related to palliative care.										
Task Step 2: Develop agreements to address coverage gaps.										
Task Step 3: Finalize agreements with MCO partners.										
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively engaged patients for project milestone reporting.										
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 3: Launch and roll out training program on interim tracking process.										
Task Step 4: Monitor implementation of interim tracking process and refine as needed.										
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.										
Task Step 9: Develop CCMS training requirements.										
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.										
Task PPS has identified primary care providers integrating palliative care services into their practice model. Primary care practices using PCMH and/or APCM have been included. The PPS has received agreement from those PCPs not PCMH and/or APCM certified to become certified to at least Level 1 of the 2014 NCQA PCMH and/or APCM by Demonstration Year 3.	237	316	316	316	316	316	316	316	316	316
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to understand primary care network PCMH certification status and capacity/readiness for palliative care integration. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess existing provider capabilities for implementing evidence-based strategies for integration of palliative care and achieving 2014 Level 1 NCQA PCMH certification. Segment providers.										
Task Step 3: Identify roles, responsibilities, and processes for integration of palliative care protocols; sign agreements with identified providers.										
Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 The PPS has developed partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the PCP practice.										
Task Step 1: Develop Partner Readiness Assessment Tool (PRAT), which includes partner-reported information of certain IT, operational, and staffing capacity and capabilities. Use PRAT to identify community and provider resources to bring palliative care supports and services into primary care practices. Educate partners on PRAT and roll out PRAT.										
Task Step 2: Analyze current state baseline data to assess existing provider capabilities provide palliative care supports and services. Segment providers.										
Task Step 3: Identify roles, responsibilities, and processes for community and provider organizations related to the integration of palliative care into the primary care setting.										
Task Step 4: Contract with partners as needed.										
Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.										
Task PPS has developed/adopted clinical guidelines agreed to by all partners including services and eligibility, that include implementation, where appropriate, of the DOH-5003 Medical Orders for Life Sustaining Treatment (MOLST) form. PPS has trained staff addressing role-appropriate competence in palliative care skills.										
Task Step 1: Convene Clinical Leadership Team to define PPS-wide guidelines for integration of palliative care protocols into the primary care setting.										
Task Step 2: Synthesize guidelines for integration of palliative care and obtain input from PAC, which is comprised of all partners including Medicaid providers, CBOs, government agencies, and other stakeholders. Coordinate with collaborating PPSs, as appropriate.										
Task Step 3: Care Models Committee reviews and makes consensus-driven recommendation on guidelines for palliative care integration.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 Step 4: Refine guidelines for palliative care integration through Hub-based planning process.										
Task Step 5: Roll out and monitor the implementation of palliative care integration. Revise as needed.										
Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.										
Task Staff has received appropriate palliative care skills training, including training on PPS care protocols.										
Task Step 1: Define PPS provider training needs for enhancing competence in palliative care skills and protocols.										
Task Step 2: Develop curriculum for training and education in palliative care protocols tailored to the primary care setting.										
Task Step 3: Identify training resources and create training plan.										
Task Step 4: Launch and roll-out palliative care training plan										
Task Step 5: Monitor training program, including the number of providers trained.										
Milestone #5 Engage with Medicaid Managed Care to address coverage of services.										
Task PPS has established agreements with MCOs that address the coverage of palliative care supports and services.										
Task Step 1: Review existing MCO contracts to determine gaps in coverage related to palliative care.										
Task Step 2: Develop agreements to address coverage gaps.										
Task Step 3: Finalize agreements with MCO partners.										
Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.										
Task PPS identifies targeted patients and is able to track actively										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project Requirements (Milestone/Task Name)	DY3,Q3	DY3,Q4	DY4,Q1	DY4,Q2	DY4,Q3	DY4,Q4	DY5,Q1	DY5,Q2	DY5,Q3	DY5,Q4
engaged patients for project milestone reporting.										
Task Step 1: Determine interim process needed to support patient identification and tracking prior to deployment of Centralized Care Coordination and Management Solution (CCMS) and related registries.										
Task Step 2: Define PPS training needs for interim tracking process. Develop curriculum; refine as needed.										
Task Step 3: Launch and roll out training program on interim tracking process.										
Task Step 4: Monitor implementation of interim tracking process and refine as needed.										
Task Step 5: Determine project scope for Care Coordination and Management Solution (CCMS) and related registries for DSRIP program implementation, in partnership with contracted vendor (GSI Health): conduct planning workshop, gather requirements, socialize requirements with key partners.										
Task Step 6: Conduct CCMS Design: review preliminary software specifications, develop functional specifications, develop prototype based on functional specifications, review functional specifications, incorporate feedback into functional specifications, obtain approval to proceed.										
Task Step 7: Develop CCMS specifications and software requirements: conduct needs analysis, draft preliminary software specifications; develop preliminary budget; review software specifications/budget with team, incorporate feedback on software specifications.										
Task Step 8: Create CCMS Documentation: develop user manual specifications, develop user manual(s), review all user documentation, incorporate user documentation feedback.										
Task Step 9: Develop CCMS training requirements.										
Task Step 10: Pilot and Roll-out of CCMS: identify test group, develop software delivery mechanism, install/deploy software, obtain user feedback, evaluate testing information; conduct user training.										

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

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

No Records Found

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text

No Records Found

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

IPQR Module 4.a.iii.1 - Major Risks to Implementation and Mitigation Strategies

Instructions :

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

1. Silos between Substance Abuse and Mental Health Services: One risk that OneCity Health confronts is that programs may not be able to overcome the existing silos between substance abuse and mental health services, and hence will primarily focus on mental health needs, while overlooking substance use needs. The CNA identified pronounced silos in care, despite the co-morbidities of MHSA conditions. Further, various evidence-based trainings focus exclusively on mental health concerns. To mitigate this risk, OneCity Health and its MHSA Collaborative Workgroup PPS partners– Bronx Partners for Healthy Communities, Community Care of Brooklyn, and Bronx Health Access–have agreed to build substance use trainings and materials that address prevention of overdose and unprotected sex and other risky behaviors into core programming. Additionally, the Workgroup includes substance use and mental health experts who will continue to ensure that the project addresses both needs in an integrated manner, and also addresses MHSA needs holistically, together with other health needs.

2. Partnership with the Department of Education: Another risk is that PPS partners will not be able to forge a constructive partnership with the Department of Education (DOE) in order to successfully pursue the school-based interventions. The PPSs have identified strong synergies between this project and DOE programming, such as DOE's investments in mental health infrastructure in approximately 100 community/renewal schools city-wide, but they will need to actively engage DOE to succeed in DSRIP-related transformations. The Workgroup has already been addressing this risk by engaging the Director of School Mental Health Services with the City's Office of School Health and individuals with the New York City Department of Health and Mental Hygiene (DOHMH) as advisory members of the Workgroup. The PPS partners will continue to engage both DOE and DOHMH in developing their approach to programming and staffing.

3. Measurement and Sustainability: Additional risks are that PPSs will lack the robust data set required to measure progress against goals and serve as an evidence base to demonstrate the cost-effectiveness of the activities and, relatedly, that MHSA activities will not be sustainable beyond the demonstration period. The PPSs will address these risks in several ways. First, the intervention aims to develop long-standing, sustainable school-based infrastructure to address MHSA needs. The project design utilizes cost-effective staffing plans and trainings to prepare non-MD school-based staff to serve as effective coaches. Further, the PPSs have committed to working together to build an evidence base to document results and cost-effectiveness. The PPSs have identified certain performance metrics, such as reductions in schools suspensions and 911 calls that they will track during the intervention. They will engage MCOs, SDOH, and DOE in discussions regarding the program's cost-effectiveness and how to finance DSRIP staff and their related school-based activities like "coaching" and referrals under a value based payment system post-DSRIP.

4. Engagement of School Staff: Another possible risk is that school-based staff will be disengaged, based on their own biases or misunderstanding of MHSA-related disease, or fears of being held responsible for individual student outcomes related to MHSA issues. To mitigate this risk, PPSs will build partnerships with teachers and school staff at the ground level. Staff trainings will address issues like bias and stigma and will educate staff about the nature of MHSA conditions. The PPSs will also train school-based staff on when to refer students with potentially more serious

problems to available referral channels and help to ensure warm handoffs to appropriate community-based MHSA services.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.a.iii.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 1. Organize and convene citywide MHSA Workgroup meetings	Completed	1. Organize and convene citywide MHSA Workgroup meetings	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Form MHSA Work Group composed of representatives of the four collaborating PPSs, including community-based representatives	Completed	Form MHSA Work Group composed of representatives of the four collaborating PPSs, including community-based representatives	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Identify PPS subject matter experts to join Work Group	Completed	Identify PPS subject matter experts to join Work Group	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Invite representatives from DOE-affiliated Office of School Health and DOHMH to join Workgroup as advisory members	Completed	Invite representatives from DOE-affiliated Office of School Health and DOHMH to join Workgroup as advisory members	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Convene Citywide MHSA Workgroup meetings under the standing structure	Completed	Convene Citywide MHSA Workgroup meetings under the standing structure	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Milestone 2. Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	In Progress	2. Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	04/01/2015	03/31/2016	04/01/2015	03/31/2016	03/31/2016	DY1 Q4
Task Confirm commitment of four collaborating PPSs to partner in City-wide implementation of MHSA Project	Completed	Confirm commitment of four collaborating PPSs to partner in City-wide implementation of MHSA Project	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Develop governance structure and process among collaborating PPSs to oversee the implementation and ongoing operation of the MHSA project, and document functions, roles,	Completed	Develop governance structure and process among collaborating PPSs to oversee the implementation and ongoing operation of the MHSA project, and document functions, roles, and responsibilities for parties including Workgroup	04/01/2015	12/31/2015	04/01/2015	12/31/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
and responsibilities for parties including Workgroup								
Milestone 3. Review existing programs and CBOs providing MHSA services, as well as adaptations of CC based model.	In Progress	3. Review existing programs and CBOs providing MHSA services, as well as adaptations of CC based model.	06/30/2015	03/31/2016	06/30/2015	03/31/2016	03/31/2016	DY1 Q4
Task Conduct baseline analysis of existing programs and CBOs providing MHSA services to adolescents in schools	Completed	Conduct baseline analysis of existing programs and CBOs providing MHSA services to adolescents in schools	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Review evidence-based adaptations of Collaborative Care (CC) model that have targeted adolescents	Completed	Review evidence-based adaptations of Collaborative Care (CC) model that have targeted adolescents	06/30/2015	12/31/2015	06/30/2015	12/31/2015	12/31/2015	DY1 Q3
Task Incorporate findings into MHSA project concept document	In Progress	Incorporate findings into MHSA project concept document	06/30/2015	03/31/2016	06/30/2015	03/31/2016	03/31/2016	DY1 Q4
Milestone 4. Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	In Progress	4. Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Engage MHSA Workgroup to develop concept paper describing the approach to strengthening the MHSA infrastructure in schools	Completed	Engage MHSA Workgroup to develop concept paper describing the approach to strengthening the MHSA infrastructure in schools	04/01/2015	09/30/2015	04/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Design/implement process to select well qualified Lead Agency to manage detailed program planning and implementation of the MHSA initiative	Completed	Design/implement process to select well qualified Lead Agency to manage detailed program planning and implementation of the MHSA initiative	06/30/2015	09/30/2015	06/30/2015	09/30/2015	09/30/2015	DY1 Q2
Task Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools,	Completed	Contract with selected Lead Agency to manage all aspects of the MHSA project including developing operational plan, selection of community mental/behavioral health agencies, selection of target schools, project staffing structure, and training curriculum	07/31/2015	12/31/2015	07/31/2015	12/31/2015	12/31/2015	DY1 Q3

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
project staffing structure, and training curriculum								
Task Develop draft operational plan for MHSA Workgroup review that incorporates development of culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation, staffing, training, and referral planning, as needed	In Progress	Develop draft operational plan for MHSA Workgroup review that incorporates development of culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation, staffing, training, and referral planning, as needed	07/31/2015	03/31/2016	07/31/2015	03/31/2016	03/31/2016	DY1 Q4
Task Finalize draft operational plan and budget; share with MHSA Collaborative PPS Governance body for approval	In Progress	Finalize draft operational plan and budget; share with MHSA Collaborative PPS Governance body for approval	07/31/2015	06/30/2016	07/31/2015	06/30/2016	06/30/2016	DY2 Q1
Milestone 5. Implement Collaborative Care (CC) Adaptation in schools	In Progress	5. Implement Collaborative Care (CC) Adaptation in schools	06/30/2015	09/30/2017	06/30/2015	09/30/2017	09/30/2017	DY3 Q2
Task Design and implement process to select and contract with community mental/behavioral agencies to implement programs in the schools	In Progress	Design and implement process to select and contract with community mental/behavioral agencies to implement programs in the schools	07/31/2015	06/30/2016	07/31/2015	06/30/2016	06/30/2016	DY2 Q1
Task Solicit DOE input on school selection methodology	In Progress	Solicit DOE input on school selection methodology	07/31/2015	09/30/2017	07/31/2015	09/30/2017	09/30/2017	DY3 Q2
Task Identify target schools for implementation of CC adaptation	In Progress	Identify target schools for implementation of CC adaptation	07/31/2015	06/30/2017	07/31/2015	06/30/2017	06/30/2017	DY3 Q1
Task Develop schedule for MHSA Project activities, including activities preparatory to launch of CC adaptation in schools such as contracting, staff recruitment and deployment, training	In Progress	Develop schedule for MHSA Project activities, including activities preparatory to launch of CC adaptation in schools such as contracting, staff recruitment and deployment, training	07/31/2015	03/31/2017	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Launch implementation of MHSA Project CC adaptation in schools	In Progress	Launch implementation of MHSA Project CC adaptation in schools	07/31/2015	09/30/2017	07/31/2015	09/30/2017	09/30/2017	DY3 Q2
Milestone	In Progress	6. Design young adult-interfacing MHSA programs (for those ages	07/31/2015	03/31/2018	07/31/2015	03/31/2018	03/31/2018	DY3 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
6. Design young adult-interfacing MHSA programs (for those ages 21-25 yrs)		21-25 yrs)						
Task Identify target young adult groups, potentially including community college students	In Progress	Identify target young adult groups, potentially including community college students	07/31/2015	03/31/2017	07/31/2015	03/31/2017	03/31/2017	DY2 Q4
Task Refine MHSA intervention to integrate programming to reach these young adult groups, including by developing culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation plan, and staffing and training plans	In Progress	Refine MHSA intervention to integrate programming to reach these young adult groups, including by developing culturally and linguistically sensitive MEB health promotion and prevention resources, data-collection and evaluation plan, and staffing and training plans	07/31/2015	03/31/2018	07/31/2015	03/31/2018	03/31/2018	DY3 Q4
Task Launch young adult programs	In Progress	Launch young adult programs	07/31/2015	03/31/2018	07/31/2015	03/31/2018	03/31/2018	DY3 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Organize and convene citywide MHSA Workgroup meetings	
2. Establish formalized structure for cross-PPS collaboration on governance and implementation of MHSA project	
3. Review existing programs and CBOs providing MHSA services, as well as adaptations of CC based model.	
4. Develop detailed MHSA project operational plan for Collaborative Care Adaptation in schools	
5. Implement Collaborative Care (CC) Adaptation in schools	
6. Design young adult-interfacing MHSA programs (for those ages 21-25 yrs)	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.a.iii.3 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project 4.c.ii – Increase early access to, and retention in, HIV care

IPQR Module 4.c.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.

The most significant risk we anticipate is the complexity of HIV and the need to focus simultaneously on the medical and social needs of patients given the history of stigma, discrimination and neglect related to the populations most impacted by the HIV epidemic and complicated by commonly co-occurring risk factors among this population (e.g., poverty, unmet behavioral health needs). To meet DSRIP goals, we must work against negative social determinants to create environments where patients receive the care needed to protect their health. This risk cannot be mitigated by one or two strategies, but must be a core component of all efforts.

Additionally, we will seek to improve service delivery to support a more welcoming and understanding environment. For example, we intend to emphasize working with community partners that can provide targeted support and outreach related to a specific population (e.g., transgender women) or related to a specific need (e.g., homelessness) and to focus on cultural competencies and integrating peers in various aspects of care. We will seek to improve the tools we have to better identify characteristics that predict delayed entry into care and significant challenges to reaching and maintaining viral load suppression. By building a better identification system, removing barriers that deter patients from seeking and accepting assistance, and by expanding our coordination with community partners we will mitigate the challenges posed by the complex network of obstacles that put individuals at high risk for HIV acquisition and preclude efforts to engage them and have them retained in HIV care.

Another risk we have identified is the collaboration between 4.c.ii and other DSRIP projects within the OneCity Health PPS. This includes a minimum of four elements; the first two are the logistical timing of intervention activities and the need to shape HIV-specific efforts within an evolving healthcare delivery system. The last two are the desire to support the success of the whole of DSRIP in an effort to strengthen the HIV response and the need to maximize resources related to workforce and IT to avoid duplication while ensuring that adequate resources are allocated to individual projects. Our strategy to mitigate this risk is to focus on approaches that we know work, including ensuring that HIV efforts function as part of a larger network of services and leveraging the model of HIV patient-centered care and co-location of services. We will build upon our strong network of HHC HIV providers and the "hub system" that has been established by OneCity Health to support communication across our PPS.

The need to extend collaborative efforts beyond our PPS multiplies the coordination risks related to OneCity Health. To meet our shared goals, we must collaborate across all PPSs with overlapping service areas. To mitigate this risk, we intend to continue to convene the 4.c.ii PPS HIV Collaborative we established. To our advantage is a long history of working with community campaigns and consortia that address different aspects of HIV care and prevention, such as the New York State Quality of Care Committee, the National Quality Center, HRSA's NYC Ryan White Part A Planning Council, the CDC HIV Prevention Planning Group, and CBO networks.

Finally, we will leverage the PPS HIV Collaborative throughout the next five years by continuing to meet with providers, colleagues and stakeholders to ensure that we share best practices, make progress toward alignment of common language and approaches whenever possible in

order to promote a consistent standard for HIV providers across the city.

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

Instructions :

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

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
Milestone 1. Convening a PPS HIV Learning Collaborative	In Progress	1. Convening a PPS HIV Learning Collaborative	07/01/2015	03/31/2020	07/01/2015	03/31/2020	03/31/2020	DY5 Q4
Task Step 1: Confirm PPS participation in HIV Collaborative throughout DSRIP implementation.	Completed	Step 1: Confirm PPS participation in HIV Collaborative throughout DSRIP implementation.	07/01/2015	09/30/2015	07/01/2015	09/30/2015	09/30/2015	DY1 Q2
Task Step 2: Contract with DOHMH to convene and support the HIV Collaborative.	In Progress	Step 2: Contract with DOHMH to convene and support the HIV Collaborative.	07/01/2015	12/31/2016	07/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 3: Develop agenda for Learning Collaborative meetings and hold meetings.	In Progress	Step 3: Develop agenda for Learning Collaborative meetings and hold meetings.	01/01/2016	03/31/2020	01/01/2016	03/31/2020	03/31/2020	DY5 Q4
Milestone 2. Establishing a work plan and timeline for project implementation.	In Progress	2. Establishing a work plan and timeline for project implementation.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Develop work plan and timeline for projects being implemented jointly across multiple PPSs.	In Progress	Step 1: Develop work plan and timeline for projects being implemented jointly across multiple PPSs.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 2: Develop work plan and timeline for additional projects being implemented by OneCity Health.	In Progress	Step 2: Develop work plan and timeline for additional projects being implemented by OneCity Health.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Validate work plans and timelines with PPS governance bodies and relevant stakeholders, as needed.	In Progress	Step 3: Validate work plans and timelines with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone 3. Developing agreed upon milestones for	In Progress	3. Developing agreed upon milestones for project implementation.	10/01/2015	03/31/2017	10/01/2015	03/31/2017	03/31/2017	DY2 Q4

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
project implementation.								
Task Step 1: Agree on voting guidelines and procedures that will support a transparent, consensus-driven process to reach agreement on project milestones across a diverse set of stakeholders	Completed	Step 1: Agree on voting guidelines and procedures that will support a transparent, consensus-driven process to reach agreement on project milestones across a diverse set of stakeholders	10/01/2015	12/31/2015	10/01/2015	12/31/2015	12/31/2015	DY1 Q3
Task Step 2: Develop and discuss set of possible milestones for projects being implemented jointly across multiple PPSs.	In Progress	Step 2: Develop and discuss set of possible milestones for projects being implemented jointly across multiple PPSs.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 3: Reach consensus on cross-PPS milestones based on agreed-upon voting/decision-making process	In Progress	Step 3: Reach consensus on cross-PPS milestones based on agreed-upon voting/decision-making process	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 4: Develop milestones for additional projects being implemented by OneCity Health.	In Progress	Step 4: Develop milestones for additional projects being implemented by OneCity Health.	10/01/2015	09/30/2016	10/01/2015	09/30/2016	09/30/2016	DY2 Q2
Task Step 5: Validate milestones with PPS governance bodies and relevant stakeholders, as needed.	In Progress	Step 5: Validate milestones with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone 4. Agree-on project commonalities and shared resources.	In Progress	4. Agree-on project commonalities and shared resources.	04/01/2015	03/31/2017	04/01/2015	03/31/2017	03/31/2017	DY2 Q4
Task Step 1: Determine 4.c.ii projects that are common across most/all PPSs in the Collaborative and a structure for sharing resources needed for implementation.	In Progress	Step 1: Determine 4.c.ii projects that are common across most/all PPSs in the Collaborative and a structure for sharing resources needed for implementation.	04/01/2015	06/30/2016	04/01/2015	06/30/2016	06/30/2016	DY2 Q1
Task Step 2: Validate agreement with PPS governance bodies and relevant stakeholders, as needed.	In Progress	Step 2: Validate agreement with PPS governance bodies and relevant stakeholders, as needed.	01/01/2016	03/31/2017	01/01/2016	03/31/2017	03/31/2017	DY2 Q4
Milestone 5. Agree-on a data sharing system to address	In Progress	5. Agree-on a data sharing system to address reporting and implementation needs.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4

New York City Health and Hospitals Corporation (PPS ID:52)

Milestone/Task Name	Status	Description	Original Start Date	Original End Date	Start Date	End Date	Quarter End Date	DSRIP Reporting Year and Quarter
reporting and implementation needs.								
Task Step 1: Determine system for sharing information across PPS and validate decision with PPS governance bodies and relevant stakeholders, as needed.	In Progress	Step 1: Determine system for sharing information across PPS and validate decision with PPS governance bodies and relevant stakeholders, as needed.	04/01/2016	03/31/2017	04/01/2016	03/31/2017	03/31/2017	DY2 Q4
Task Step 2: Contract with system developer/administrator, as needed.	In Progress	Step 2: Contract with system developer/administrator, as needed.	07/01/2016	03/31/2017	07/01/2016	03/31/2017	03/31/2017	DY2 Q4

PPS Defined Milestones Current File Uploads

Milestone Name	User ID	File Type	File Name	Description	Upload Date

No Records Found

PPS Defined Milestones Narrative Text

Milestone Name	Narrative Text
1. Convening a PPS HIV Learning Collaborative	
2. Establishing a work plan and timeline for project implementation.	
3. Developing agreed upon milestones for project implementation.	
4. Agree-on project commonalities and shared resources.	
5. Agree-on a data sharing system to address reporting and implementation needs.	

Module Review Status

Review Status	IA Formal Comments
Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

IPQR Module 4.c.ii.3 - IA Monitoring

Instructions :

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 'New York City Health and Hospitals Corporation ', 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:	JACOBI MEDICAL CENTER
Secondary Lead PPS Provider:	
Lead Representative:	Christina Jenkins
Submission Date:	03/16/2016 12:58 PM

Comments:	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Status Log				
Quarterly Report (DY,Q)	**Status**	**Lead Representative Name**	**User ID**	**Date Timestamp**
DY1, Q3	Adjudicated	Christina Jenkins	emcgill	03/31/2016 05:19 PM
DY1, Q3	Submitted	Christina Jenkins	jenkinsc	03/16/2016 12:58 PM
DY1, Q3	Returned	Christina Jenkins	emcgill	03/01/2016 05:14 PM
DY1, Q3	Submitted	Christina Jenkins	jenkinsc	02/01/2016 02:27 PM
DY1, Q3	In Process		ETL	01/03/2016 08:01 PM

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Comments Log			
Status	**Comments**	**User ID**	**Date Timestamp**
Adjudicated	The IA has adjudicated the DY1 Q3 Quarterly Report.	emcgill	03/31/2016 05:19 PM
Returned	No additional comments	jenkinsc	03/16/2016 12:58 PM
Returned	The IA is returning the DY1Q3 Quarterly Report to the PPS for Remediation.	emcgill	03/01/2016 05:14 PM

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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 & Ongoing	
	Module 1.5 - Prescribed Milestones		
	Milestone #1 Complete funds flow budget and distribution plan and communicate with network	Pass & Ongoing	
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	Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section	Module Name / Milestone #	Review Status	
	latest		
	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.	Pass & Complete	
	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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Section	Module Name / Milestone #	Review Status	
	Milestone #2 Develop a Clinical Integration strategy.	Pass & Ongoing	
Section 11	Module 11.2 - Prescribed Milestones		
	Milestone #1 Define target workforce state (in line with DSRIP program's goals).	Pass & Ongoing	
	Milestone #2 Create a workforce transition roadmap for achieving defined target workforce state.	Pass & Ongoing	
	Milestone #3 Perform detailed gap analysis between current state assessment of workforce and projected future state.	Pass & Ongoing	
	Milestone #4 Produce a compensation and benefit analysis, covering impacts on both retrained and redeployed staff, as well as new hires, particularly focusing on full and partial placements.	Pass & Ongoing	
	Milestone #5 Develop training strategy.	Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

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.a.iii	Module 2.a.iii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.a.iii.3 - Prescribed Milestones		
	Milestone #1 Develop a Health Home At-Risk Intervention Program, utilizing participating HHs as well as PCMH/APC PCPs in care coordination within the program.	Pass & Ongoing	
	Milestone #2 Ensure all primary care providers participating in the project meet NCQA (2011) accredited Patient Centered Medical Home, Level 3 standards and will achieve NCQA 2014 Level 3 PCMH and Advanced Primary Care accreditation by Demonstration Year (DY) 3.	Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	Milestone #3 Ensure that all participating safety net providers are actively sharing EHR systems with local health information exchange/RHIO/SHIN-NY and sharing health information among clinical partners, including direct exchange (secure messaging), alerts and patient record look up.	Pass & Ongoing	
	Milestone #4 Ensure that EHR systems used by participating safety net providers meet Meaningful Use and PCMH Level 3 standards and/or APCM.	Pass & Ongoing	
	Milestone #5 Perform population health management by actively using EHRs and other IT platforms, including use of targeted patient registries, for all participating safety net providers.	Pass & Ongoing	
	Milestone #6 Develop a comprehensive care management plan for each patient to engage him/her in care and to reduce patient risk factors.	Pass & Ongoing	
	Milestone #7 Establish partnerships between primary care providers and the local Health Home for care management services. This plan should clearly delineate roles and responsibilities for both parties.	Pass & Ongoing	
	Milestone #8 Establish partnerships between the primary care providers, in concert with the Health Home, with network resources for needed services. Where necessary, the provider will work with local government units (such as SPOAs and public health departments).	Pass & Ongoing	
	Milestone #9 Implement evidence-based practice guidelines to address risk factor reduction as well as to ensure appropriate management of chronic diseases. Develop educational materials consistent with cultural and linguistic needs of the population.	Pass & Ongoing	
2.b.iii	Module 2.b.iii.2 - Patient Engagement Speed	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. b. Develop process and procedures to establish connectivity between the emergency department and community primary care providers. c. Ensure real time notification to a Health Home care manager as applicable	Pass & Ongoing	
	Milestone #3 For patients presenting with minor illnesses who do not have a primary care provider: a. Patient navigators will assist the presenting patient to receive an immediate appointment with a primary care provider, after required medical screening examination, to validate a non-emergency need. b. Patient navigator will assist the patient with identifying and accessing needed community support resources. c. Patient navigator will assist the member in receiving a timely appointment with that provider's office (for patients with a primary care provider).	Pass & 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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	Milestone #5 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
2.b.iv	Module 2.b.iv.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 2.b.iv.3 - Prescribed Milestones		
	Milestone #1 Develop standardized protocols for a Care Transitions Intervention Model with all participating hospitals, partnering with a home care service or other appropriate community agency.	Pass & Ongoing	
	Milestone #2 Engage with the Medicaid Managed Care Organizations and Health Homes to develop transition of care protocols that will ensure appropriate post-discharge protocols are followed.	Pass & Ongoing	
	Milestone #3 Ensure required social services participate in the project.	Pass & Ongoing	
	Milestone #4 Transition of care protocols will include early notification of planned discharges and the ability of the transition care manager to visit the patient in the hospital to develop the transition of care services.	Pass & Ongoing	
	Milestone #5 Protocols will include care record transitions with timely updates provided to the members' providers, particularly primary care provider.	Pass & Ongoing	
	Milestone #6 Ensure that a 30-day transition of care period is established.	Pass & Ongoing	
	Milestone #7 Use EHRs and other technical platforms to track all patients engaged in the project.	Pass & Ongoing	
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 & Ongoing	
	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 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.	Pass & Ongoing	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	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	
	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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	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.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	

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

DSRIP Implementation Plan Project

New York City Health and Hospitals Corporation (PPS ID:52)

Project ID	Module Name / Milestone #	Review Status	
	Milestone #5 Use the EHR to prompt providers to complete the 5 A's of tobacco control (Ask, Assess, Advise, Assist, and Arrange).	Pass & Ongoing	
	Milestone #6 Adopt and follow standardized treatment protocols for hypertension and elevated cholesterol.	Pass & Ongoing	
	Milestone #7 Develop care coordination teams including use of nursing staff, pharmacists, dieticians and community health workers to address lifestyle changes, medication adherence, health literacy issues, and patient self-efficacy and confidence in self-management.	Pass & Ongoing	
	Milestone #8 Provide opportunities for follow-up blood pressure checks without a copayment or advanced appointment.	Pass & Ongoing	
	Milestone #9 Ensure that all staff involved in measuring and recording blood pressure are using correct measurement techniques and equipment.	Pass & Ongoing	
	Milestone #10 Identify patients who have repeated elevated blood pressure readings in the medical record but do not have a diagnosis of hypertension and schedule them for a hypertension visit.	Pass & Ongoing	
	Milestone #11 Prescribe once-daily regimens or fixed-dose combination pills when appropriate.	Pass & Ongoing	
	Milestone #12 Document patient driven self-management goals in the medical record and review with patients at each visit.	Pass & Ongoing	
	Milestone #13 Follow up with referrals to community based programs to document participation and behavioral and health status changes.	Pass & Ongoing	
	Milestone #14 Develop and implement protocols for home blood pressure monitoring with follow up support.	Pass & Ongoing	
	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.d.ii	Module 3.d.ii.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.d.ii.3 - Prescribed Milestones		
	Milestone #1 Expand asthma home-based self-management program to include home environmental trigger reduction, self-monitoring, medication use, and medical follow-up.	Pass & Ongoing	
	Milestone #2 Establish procedures to provide, coordinate, or link the client to resources for evidence-based trigger reduction interventions. Specifically, change the patient's indoor environment to reduce exposure to asthma triggers such as pests, mold, and second hand smoke.	Pass & Ongoing	
	Milestone #3 Develop and implement evidence-based asthma management guidelines.	Pass & Ongoing	

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	Milestone #4 Implement training and asthma self-management education services, including basic facts about asthma, proper medication use, identification and avoidance of environmental exposures that worsen asthma, self-monitoring of asthma symptoms and asthma control, and using written asthma action plans.	Pass & Ongoing	
	Milestone #5 Ensure coordinated care for asthma patients includes social services and support.	Pass & Ongoing	
	Milestone #6 Implement periodic follow-up services, particularly after ED or hospital visit occurs, to provide patients with root cause analysis of what happened and how to avoid future events.	Pass & Ongoing	
	Milestone #7 Ensure communication, coordination, and continuity of care with Medicaid Managed Care plans, Health Home care managers, primary care providers, and specialty providers.	Pass & Ongoing	
	Milestone #8 Use EHRs or other technical platforms to track all patients engaged in this project.	Pass & Ongoing	
3.g.i	Module 3.g.i.2 - Patient Engagement Speed	Pass & Ongoing	
	Module 3.g.i.3 - Prescribed Milestones		
	Milestone #1 Integrate Palliative Care into appropriate participating PCPs that have, or will have, achieved NCQA PCMH and/or APCM certification.	Pass & Ongoing	
	Milestone #2 Develop partnerships with community and provider resources including Hospice to bring the palliative care supports and services into the practice.	Pass & Ongoing	
	Milestone #3 Develop and adopt clinical guidelines agreed to by all partners including services and eligibility.	Pass & Ongoing	
	Milestone #4 Engage staff in trainings to increase role-appropriate competence in palliative care skills and protocols developed by the PPS.	Pass & Ongoing	
	Milestone #5 Engage with Medicaid Managed Care to address coverage of services.	Pass & Ongoing	
	Milestone #6 Use EHRs or other IT platforms to track all patients engaged in this project.	Pass & Ongoing	
4.a.iii	Module 4.a.iii.2 - PPS Defined Milestones	Pass & Ongoing	
4.c.ii	Module 4.c.ii.2 - PPS Defined Milestones	Pass & Ongoing	